

07123

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22				c. LENGTH OF STAY IN 1b 21 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7302 Dunmanway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUSTIN VICTOR ACHE				4. DATE OF DEATH Month Day Year July 1st, 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1885	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoist Eng.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Ache				14. MOTHER'S MAIDEN NAME Amanda Lynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 012-10-552		17. INFORMANT Address Anna M. Ache 7302 Dunmanway, Dundalk			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease 5 yrs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 minute	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12-57 19, to 7-1-57 19, that I last saw the deceased alive on 7-1- 19 57 , and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. K. Wong M.D. 6801 Belair Rd. Balt 6 Md. 7/3/57							
ACTUAL SIGNATURE WYMAN K. WONG		PHYSICIAN'S NAME (Type) WYMAN K. WONG					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/57		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Hellertown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Walt Brown Bradley, Inc.				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR 8 1957	
24b. REGISTRAR'S SIGNATURE Am. Kelly							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 8

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07110

Reg. Dist. No. 30

07136

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN TB 212-4146 116157			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 641 N. AUGUSTA AV., BALTO, 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ALBRECHT			4. DATE OF DEATH Month Day Year July 6, 1957		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-65	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stock Clerk, Hopper McGaw			10b. KIND OF BUSINESS OR INDUSTRY MD.		
11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME FREDERICK ALBRECHT			14. MOTHER'S MAIDEN NAME WHILMINA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MRS. LOUISA MUND Address 641 N. AUGUSTA AV., BALTO. 29		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arterio Sclerosis. Conditions, if any, which gave rise to immediate cause (b) Malnutrition gave rise to immediate cause (c) Dehydration stating the underlying cause last. Hematoma chest left 190 days					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 903.7 Antero lateral Senile Psychoses					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall on hospital ward			
20c. TIME OF INJURY Month, Day, Year Unknown 6/17/57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Catonsville	(County) md	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE W. F. McGraw		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/6/57	
EXAMINER'S NAME (Type) W. F. McGraw M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jul. 8/57	22c. NAME OF CEMETERY OR CREMATORY London Park Cemetery	22d. LOCATION (City, town, or county) Balto. Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave		ADDRESS 4101 Edmondson Ave		24a. REC'D BY REGISTRAR 7/8/57	24b. REGISTRAR'S SIGNATURE R. J. Hedrich

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

07137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTCH CLIFF NEARTOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO RURAL TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENARM ROAD</u>		d. STREET ADDRESS <u>1 GLENARM ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>SISTER MARY BENONITA ALLMANN</u>		4. DATE OF DEATH <u>JULY 27 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>GATES, NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB GEORGE</u>		14. MOTHER'S MAIDEN NAME <u>JULIANA DOERNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>0</u>		16. SOCIAL SECURITY NO. <u>493X</u>	
17. INFORMANT <u>SISTER M. PETER FOURIER</u>		Address <u>NOTCH CLIFF, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSON'S SYNDROME</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>52</u> , to <u>JULY</u> , 19 <u>57</u> that I last saw the deceased alive on <u>JULY 23rd</u> , 19 <u>57</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		ADDRESS (Street, city or town, state) <u>M.D. 1501 YORK RD. TOWSON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>		DATE SIGNED <u>7/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Villa Maria Laem.</u>	22d. LOCATION (City, town, or county) (State) <u>Notch Cliff in Towson, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zeiler</u>		24a. REC'D BY REGISTRAR <u>7/29/57</u>	
ADDRESS <u>901 S. CONKLING ST. BALTO, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Notch Cliff</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 3

JUL 30 1957

RECEIVED

07138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines Nursing Home		d. STREET ADDRESS 1725 Selma Avenue	
3. NAME OF DECEASED (Type or print) First Sherman H. Middle Atherton Last		4. DATE OF DEATH July 1, 1957 Month July Day 1 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Worcester, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gayland Atherton		14. MOTHER'S MAIDEN NAME Lucia Hesselton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Victoria Atherton		Address 1725 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident - Hemiparesis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1957 to 7/1 , 19 57 , that I last saw the deceased alive on 7/1/57 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. H. Gleditsch M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE 5 57		24b. REGISTRAR'S SIGNATURE Out with	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07113

07139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b 3½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1802 N. Milton Ave.	
3. NAME OF DECEASED (Type or print) First Emma Middle M Last Bafford		4. DATE OF DEATH Month 7 Day 8 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 8 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitress		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		17. INFORMANT Admission Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis 15 yrs. (c) 2 wks.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 1. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10 , 19 53 , to 7/8/ , 19 57 , that I last saw the deceased alive on 7/7/ , 19 57 , and that death occurred at 6:42P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd. 7/8/57 DATE SIGNED	
PHYSICIAN'S NAME (Type) Charles F O'Donnell		Tolson #4 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-11-57	London Park NATI	BALTO Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J Ruck		ADDRESS 5305 Hanford.	
24a. REC'D BY REGISTRAR DATE JUL 10 57		24b. REGISTRAR'S SIGNATURE Outback	

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 10 1957

RECEIVED

07140

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>12312</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>34 W. Belkiss Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>E.</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Broker/Parmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Parvener</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles W. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Emma Michael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Frank E. Baker</u> Address <u>34 W Belkiss Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diverticulitis & Colic</u> 5/12/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>Art. Sclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm B. Allen</u> M.D.				ADDRESS (Street, city or town, state) <u>6 E. Eager St. Balt 2</u> DATE SIGNED <u>7-13-57</u>			
NAME (Type) <u>WARDE B. ALLEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarnoff</u>				ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 15 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

Baltimore

Lutherville

College Manor

Frank

W

M

Charles W. Baker

W.D.

Abodeson

Baker

E.

City, Md.

W

M.D.

Emma Baker

July

8-1

BUREAU V. S.

JUL 17 1957

RECEIVED

07141

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 44 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE A. BANKARD		4. DATE OF DEATH Month Day Year 7/17 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BANKARD		14. MOTHER'S MAIDEN NAME ANNIE RICHERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) UNK (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORD	
17. INFORMANT Address HOSPITAL RECORD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE			
420.0 DUE TO (b) ARTERIOSCLEROTIC Heart disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 14, 1913 , to JULY 17, 1957 , that I last saw the deceased alive on JULY 17, 1957 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) DATE SIGNED Spring Grove State Hosp. 7-17-57	
PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.		Catonville 22, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-19-57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 22 57	
		24b. REGISTRAR'S SIGNATURE W. Wachslor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 22 1957

DEAN V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

07142

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN lb <u>5yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6008 Mannington Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George E. Barnhart</u>		4. DATE OF DEATH Month Day Year <u>July 18 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham E. Barnhart</u>		14. MOTHER'S MAIDEN NAME <u>Sue E. Frey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2I3-07-8897</u>	
17. INFORMANT <u>Genevieve M. Barnhart</u>		Address <u>6008 Mannington Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>OBESITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1500 Sprained ankle</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1956</u> to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 11, 1957</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		M.D. <u>1010 NORTH POINT RD</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>		<u>1010 NORTH PT. RD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hampden Township, Cumberland Co. Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wassah Funeral Home 7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Pineda</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 22 1957
BUREAU V. S.

Item 21 Film 219 8-1-57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07143

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (7th)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (7th)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3611 Patterson Ave Balt 17th md</u>		d. STREET ADDRESS <u>3611 Patterson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Donald A. Bell</u>		4. DATE OF DEATH <u>7 9 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25 1927</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. FUNDING YEAR <u>29</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Verhel W. Bell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tschudy</u>	
15. WAS DECEASED EVER IN A SEALED FORCEN? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Dr Arthur Bell</u>		18. ADDRESS <u>Pikesville md</u>	
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inadvertent overdose of Alcohol & Barbiturates</u> DUE TO (b) <u>588.0</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anxiety state severe (under active therapy)</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY <u>4:00</u> Hour o. m. <u>7/9/57</u> Month Day, Year	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Baltimore 7 md</u> (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W.E. McGroth</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W.E. McGroth</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/9/57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens & Sons - Balt 17th</u>		24a. REC'D BY REGISTRAR <u>7/13/57</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1709 Edmondson Ave.

RECEIVED
JUL 16 1957
BUREAU V. S.

07147

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 W. Penn. Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Reed Last Britton				4. DATE OF DEATH Month 7 Day 10 Year 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-1869	9. AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Taylor				14. MOTHER'S MAIDEN NAME Sarah E. Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Richard N. Britton Address Towson 4, Md. Pa. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 441X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 9 , 19 57 , to July 10 , 19 57 , that I last saw the deceased alive on July 9 , 19 57 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md DATE SIGNED 7/11/57 ACTUAL SIGNATURE George T. Gilmore M.D. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE LUTHERVILLE, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-12-57	22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks ADDRESS 622 York Rd. Towson 4, Md.				24a. REC'D BY REGISTRAR July 11, 1957	24b. REGISTRAR'S SIGNATURE Mabel C. Gray		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

JUL 12 1957

RECEIVED

07144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE <u>MD</u> COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 Alden Road</u>				d. STREET ADDRESS <u>2900 Alden Road</u>			
3. NAME OF DECEASED (Type or print) <u>JEANNE Ethel Belle</u>				4. DATE OF DEATH <u>July - 9 - 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10 - 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ph. Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York - N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Belle Adde</u>				14. MOTHER'S MAIDEN NAME <u>Helen Rooney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Louis Belle - 2900 Alden Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Cardio-Vascular dis.</u> DUE TO <u>Thrombo-Phlebitis migrans</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Paralytic ileus</u> (b) <u>---</u> (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs + 6 mos + 1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October 1950</u> to <u>July 9, 1957</u> , that I last saw the deceased alive on <u>July 8, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>C. M. Bacon</u> M.D. <u>2810 Taylor Ave.</u>				<u>7/9/57</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>				<u>Baltimore - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Interment</u>		<u>July 19/57</u>		<u>Union Cemetery</u>		<u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Christopher - 1330 Fulton Pl.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				<u>DATE 7/10/57</u>		<u>Dr. C. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 14 1957

BUREAU V. S.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07119
38

07145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - City of Baltimore		c. LENGTH OF STAY IN 1b 2 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6440 Bellona Avenue Mercy Villa Nursing Home	
d. STREET ADDRESS 2507 N. Calvert Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mrs. Theresa O'Neill Bernard		4. DATE OF DEATH Month Day Year July 22 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 80 yrs.
9. AGE (In years last birthday) About 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Owen O'Neill		14. MOTHER'S MAIDEN NAME Ellen ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address Mr. Roland O'Neill - 4329 Falls Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic Myocardial Disease July 25 1955 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerosis (c) Chronic Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1.25
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 25 1955 to July 22 1957 , that I last saw the deceased alive on July 22 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3013 N. Calvert St. Baltimore, Md. DATE SIGNED July 23 1957 ACTUAL SIGNATURE Charles W. Lawrence M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/57	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Messersmith		ADDRESS 805 N. Calvert St.	24a. REC'D BY REGISTRAR 7/25/57
		24b. REGISTRAR'S SIGNATURE Mabel Gray	

RECEIVED

26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07146

CERTIFICATE OF DEATH

07120

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
c. LENGTH OF STAY IN 1b <u>18mo.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Glade Ave</u>				d. STREET ADDRESS <u>14 Glade Ave</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Barbara</u> Last <u>Braid</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 16 1870</u>	
				9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Politz</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>None</u>			
				17. INFORMANT <u>Jeannette Bichell</u> Address <u>14 Glade Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia...aspiration</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident with Pharyngeal Paresis</u> DUE TO (c) <u>Atherosclerosis Generalized-Severe & Hypertension</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>14 days</u> <u>undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>441X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 July</u> , 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7527 Belair Rd Balto 6 Md</u> DATE SIGNED <u>17 July 57</u> ACTUAL SIGNATURE <u>John C. Hyle</u> M.D. PHYSICIAN'S NAME (Type) <u>John C. Hyle MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duggel Bros. 7110 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>	

WILLIAM V. S.

101

101-101-101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07148

CERTIFICATE OF DEATH

07122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 29yr2mth8dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 1227 Poplar Grove St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hedwig Middle Last Brucksch			4. DATE OF DEATH Month July Day 1 Year 19 57				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓
13. FATHER'S NAME Roman Brucksch			14. MOTHER'S MAIDEN NAME Augusta Pirene				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 54 , to July 1 , 19 57 , that I last saw the deceased alive on July 1 , 19 57 , and that death occurred at 3:40p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 7-2-57 PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-57		22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 8 57	
				24b. REGISTRAR'S SIGNATURE W. Wachslar			

WILSON V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07149 CERTIFICATE OF DEATH

07123
45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20 Md.</u>		c. LENGTH OF STAY IN 1b <u>11 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 209 Route 14</u>		e. STREET ADDRESS <u>Silbquille Del.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna P. Bunting</u>		f. DATE OF DEATH <u>July 16 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1880</u>
9. AGE (In years, for birthday) <u>77</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Tingle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Dr. Victor Emanuel</u>		Address <u>Balt 20 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>1 yr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8, 1957</u> , to <u>July 16, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u>		M.D. <u>108 S. Taylor Ave</u>	
PHYSICIAN'S NAME (Type) <u>Joseph Miceli, M.D.</u>		ADDRESS (Street, city or town, state) <u>Excess 21 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>L.O.O.F.</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. W. Haley</u>		24a. REG'D BY REGISTRAR <u>Jul 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Edith Stanley</u>			

RECEIVED
JUL 10 1967
BUREAU F. B.

07150

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7500 MARLBORO DRIVE</u>		d. STREET ADDRESS <u>901 AISQUITH ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SR. M. FILIONA HELEN BURKE</u>		4. DATE OF DEATH Month Day Year <u>JULY 26, 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>BOSTON, MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>EDMOND BURKE</u>		14. MOTHER'S MAIDEN NAME <u>? McREA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SR. M. STAN. KOSKA</u>		Address <u>SAME.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Cardiovascular disease</u> DUE TO (c) <u>20 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>400.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1953</u> to <u>July 1957</u> that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>430 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent de P. Fitzpatrick M.D.</u>		ADDRESS (Street, city or town, state) <u>1120 St. Paul St.</u>	
DATE SIGNED <u>7/27/57</u>			
PHYSICIAN'S NAME (Type) <u>Vincent de P. Fitzpatrick Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SISTERS' CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CHAS. ST. & HOMELAND AVES.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gailer</u>		ADDRESS <u>901 S CONKLING ST. BALTO. 24, MD.</u>	
DATE <u>JUL 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. B...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 30 1957

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07151

CERTIFICATE OF DEATH

07125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>34</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1924 Wilkens Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Baulah</u> Middle <u>Carmen</u> Last <u>Calder</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Parker</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Hottle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>100.0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12</u> , 19 <u>57</u> , to <u>July 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>57</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7-15-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>CATONSVILLE 28, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DATE 7-18-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Deane</u>			

RECEIVED
JUL 18 1957
BUREAU Y. S.

07152

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>5 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Cockeysville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>1 Wight Ave.</i>	
3. NAME OF DECEASED: (Type or Print) <i>Emma Elizabeth Clausen</i>		4. DATE OF DEATH: (Month) (Day) (Year) <i>July 16 1957</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>July 4, 1869</i>
9. AGE last birthday: <i>88</i> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Maryland.</i>
13. FATHER'S NAME: <i>Balthasar Beyer</i>		14. MOTHER'S MAIDEN NAME: <i>Anna Gertrude (unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Mrs. Emma Ziegler - Cockeysville, Md.</i>	
16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		years.	
(A) IMMEDIATE CAUSE: <i>Arteriosclerotic cardio-vascular disease</i>			
(B) ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June, 1953</i> , to <i>July, 1957</i> , that I last saw the deceased alive on <i>July 1, 1957</i> , and that death occurred at <i>3:45 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Elizabeth B. Sherrill</i>		ADDRESS <i>Cockeysville Md.</i> DATE SIGNED <i>7/16/57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>7/19/57</i>	
NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Pk. Anne Arundel, Md.</i>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <i>7/17/57</i>		REGISTRAR'S SIGNATURE <i>A. W. Hedrick, Jr.</i>	
24. FUNERAL DIRECTOR <i>Wm. Cook-Towson Inc</i>		ADDRESS <i>Towson #4</i>	

JOHN A. S.

1857

1857

07153

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek, Maryland</u>				d. STREET ADDRESS <u>P.O. #1, Box 232</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Edna</u> Last <u>Clements</u>				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/56</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Gerald Clements</u>				14. MOTHER'S MAIDEN NAME <u>Adelta Agnes Lint</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Parents and Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure due to heart malformation (Tetralogy of Fallot)</u> DUE TO (b) <u>754.0</u> DUE TO (c) <u>Mongoloid idiocy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/56</u> , 19 <u>56</u> , to <u>7/21/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/21/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u> DATE SIGNED <u>7/25/57</u>							
ACTUAL SIGNATURE <u>Harry G. Butler</u>				M.D. <u>Owings Mills, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Harry G. Butler</u>				Rosewood State Training School			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Chambers</u>				ADDRESS <u>1400 Chopin St. NW</u>		24. REC'D BY REGISTRAR <u>Wm Chambers</u>	
				DATE <u>JUL 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 27 1957

BUREAU V. S.

07154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>				e. STREET ADDRESS <u>3915 Pinney Road</u>			
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First Middle Last <u>Cohen</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army & Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Rubin</u>				14. MOTHER'S MAIDEN NAME <u>Rachael</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nathan M Cowan</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>10 yrs. (?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7-5</u> 19 <u>57</u> , to <u>7-25</u> 19 <u>57</u> , that I last saw the deceased alive on <u>7-25</u> 19 <u>57</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>7-25-57</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Catonsville-25, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-26-57</u>		<u>Hebrew Young Men</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Guitaw Place</u>				24a. REC'D BY REGISTRAR DATE <u>29</u>		24. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, should be filed with page 3. I be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

07155

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston		c. LENGTH OF STAY IN lb ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Park Heights Ave.				d. STREET ADDRESS Park Heights Ave.			
3. NAME OF DECEASED (Type or print) Rev. Robert Henry Coleman				4. DATE OF DEATH Month July Day 1 Year 1957			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1920	9. AGE (in years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Protestant Episcopal Clergy		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Caldwell Coleman				14. MOTHER'S MAIDEN NAME Elizabeth C. Brooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Address Hon. Wm. C. Coleman, Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death by strangulation due to hanging-suicide DUE TO 4x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6-7 hrs. (est.)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient hung self on shower bar with his belt.					
20c. TIME OF INJURY Month, Day, Year 8-9 a.m. est. 7/1/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Eccleston, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-2-57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Thomas		22d. LOCATION (City, town, or county) (State) Garrison Forest, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co., 4905 York Rd.				24a. REC'D BY REGISTRAR DATE 7/3/57		24b. REGISTRAR'S SIGNATURE Dorothy Russell	

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Item 9 10-10-1957 7-15-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07157
CERTIFICATE OF DEATH

07131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>4 Months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Presbyterian Home of Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7107 Windsor Mill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Dorothy E.</u> Middle <u>Conrad</u> Last <u></u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1957</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 22, 1866</u>		9. AGE (In years last birthday) <u>90</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>									
13. FATHER'S NAME <u>August Miltz</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Presbyterian Home</u> <u>Towson, Md.</u>				Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Renal Vascular Disease - advanced senile changes</u> <u>442X</u> DUE TO (b) <u>Arteriosclerosis (and aging)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericious Anemia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Jan 4</u> <u>1957</u> to <u>July 2</u> <u>1957</u> that I last saw the deceased alive on <u>June 29</u> <u>1957</u> and that death occurred at <u>9:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Towson 4 Md</u> DATE SIGNED <u>7/2/57</u>																	
ACTUAL SIGNATURE <u>Rollin C. Hudson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Rollin C. Hudson M.D.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>				ADDRESS <u>1900 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Gray</u>									

RECEIVED

1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07158

CERTIFICATE OF DEATH

07132

32

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md. b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. LENGTH OF STAY IN 1b 61 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. STREET ADDRESS 430 E. Church St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Severn Warner Crockett				4. DATE OF DEATH Month Day Year 7 6 1957			
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/94	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry S. Crockett				14. MOTHER'S MAIDEN NAME Sadie Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Maggie N. Crockett (Wife) Sal. Md. Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/6 , 19 57 , to 7/6/57 , 19 57 , that I last saw the deceased alive on 7/6 , 19 57 , and that death occurred at 6:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED July 6, 1957							
ACTUAL SIGNATURE William Newcomer M.D.							
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE JUL 13 1957			
				24b. REGISTRAR'S SIGNATURE Bertha Russell			

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JUL 10 1957
BUREAU V. 31

07159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Box 90, Dares Beach, Md. Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dares Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle Mae Last Dement				4. DATE OF DEATH Month July Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-23-78	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel B.				14. MOTHER'S MAIDEN NAME Katherine Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Bernard Dement Address Box 90 Dares Beach, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 443X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21 , 19 57 , to July 13 , 19 57 , that I last saw the deceased alive on July 13 , 19 57 , and that death occurred at 5:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas				ADDRESS (Street, city or town, state) Spring Grove St. Hop. Catonsville, Md			
PHYSICIAN'S NAME (Type) Bruno Radauskas				DATE SIGNED 7/13/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-16-57		Cedar Hill		Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Mattingly				ADDRESS 131-11		24. REGISTRAR'S SIGNATURE Jul 15 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07134 41

07124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6807 5th.Ave.		d. STREET ADDRESS 6807 5th.Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Felix Middle Dudzinski Last Dudzinski		4. DATE OF DEATH Month July Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct.16,1889
9. AGE (In years last birthday) yrs. 67		IF UNDER 1 YEAR: Months 6 Days 12 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Dudzinski		14. MOTHER'S MAIDEN NAME Josephine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 180-01-4862	
17. INFORMANT Bertha Dudzinski		Address 6807 5th.Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis - especially coronary DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hr 4 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/5, 1957 to 7/12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R Maurice Feldman M.D.		ADDRESS (Street, city or town, state) Reutsky, Charles St. Balto DATE SIGNED 7/13/57	
PHYSICIAN'S NAME (Type) / Maurice Feldman Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/15/57	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Balto.Co.Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski		ADDRESS 2007 Eastern Ave	
24a. REC'D BY REGISTRAR 15 1957		24b. REGISTRAR'S SIGNATURE Am. Kelly	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. This permit should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 5-11-57 at

CERTIFICATE OF DEATH

07135

07160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN lb <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 21, D. C.</u>			
f. STREET ADDRESS <u>5913 - 23rd Place, S. E.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>THEODORE</u> Last <u>DUEVER, SR</u>				4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-1885</u>	
9. AGE (In years last birthday) <u>71 1/2</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min <u>00</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Missouri</u>			
13. FATHER'S NAME <u>William Duever</u>				14. MOTHER'S MAIDEN NAME <u>Mary Reiners</u>			
15. DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Vasconcellos</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerodis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome due to cerebral arteriosclerodis - depression</u> <u>420.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>57</u> , to <u>7-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-5</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED _____ SIGNATURE <u>John Vasconcellos</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>John Vasconcellos</u> <u>Baltimore, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. Lee + Son's Co.</u>				24a. REC'D BY REGISTRAR <u>300 4th St. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

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07161

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 18 Hrs. 25 Min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 32B Westway North				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First JOHN Middle E. Last DUKES				4 DATE OF DEATH Month July Day 8 Year 1957			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH December 18, 1894	
9 AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Air Craft Co.		11 BIRTHPLACE (State or foreign country) Hoopers Island, Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S. A.							
13 FATHER'S NAME Franklin Dukes				14 MOTHER'S MAIDEN NAME Mary Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 218-05-8400		17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION WITH MYOCARDIAL FOCAL NECROSIS 420.1 MYX AND OLD INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6:15 PM	
20f. (City or town) VA				20g. (County) VAH		20h. (State) MD	
21. I certify that VA attended the deceased from July 7, 1957 to July 8, 1957 and that death occurred at 12:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				DATE SIGNED 7/9/57			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				ADDRESS 6009 Harford Rd., Balto 14, Md.		24a. REC'D BY REGISTRAR DATE 7/12/57	
24b. REGISTRAR'S SIGNATURE Dr. Damaskus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MIL 15 1957

RECEIVED

07162

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>		d. STREET ADDRESS <u>119 S. Tremont Road</u>	
3. NAME OF DECEASED (Type or print) <u>ESTELLA EMMA-EDELER</u>		4. DATE OF DEATH <u>July 31 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. Miles</u>		14. MOTHER'S MAIDEN NAME <u>Emma Gopp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ruth E. Groves</u>		Address <u>119 S. Tremont Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident (Probably hemorrhage)</u> DUE TO <u>Hypertensive arteriosclerotic cardio vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>disease</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3ix</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1957</u> to <u>July 31, 1957</u> , that I last saw the deceased alive on <u>July 31, 1957</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Knipp</u> M.D.		ADDRESS (Street, city or town, state) <u>4116 Edmondson Avenue</u> DATE SIGNED <u>8/1/57</u>	
PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>		<u>Baltimore 29, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 3-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louclon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Guifel</u> ADDRESS <u>5311 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 2 57</u>	24b. REGISTRAR'S SIGNATURE <u>Red Leach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07138

07163

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 168 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2915 S. Denham Circle			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EARLE N. EDWARDS				4. DATE OF DEATH Month Day Year July 22 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1920	
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Brick Yard		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Earle B. Edwards				14. MOTHER'S MAIDEN NAME Gladys G. Gross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or date of service) WW II				16. SOCIAL SECURITY NO 214-14-0798		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 121X PYELONEPHRITIS WITH PYONEPHROSIS, BILATERAL DUE TO CARCINOMA OF BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 600.C (b) METASTATIC LESION TO PELVIC FLOOR, PELVIC BONE (c) CARCINOMA OF BLADDER AND PROSTATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS 2 1/2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation, 10/15/56, Bilateral Ureterosigmoidostomy				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 4, 1957 to July 22, 1957 and that death occurred at 5:22 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 7/23/57							
ACTUAL SIGNATURE Chien Wei Lan				PHYSICIAN'S NAME (Type) CH IEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802 Madison Ave., Balto., Md.		24a. REC'D BY REGISTRAR 7/25/57	
24b. REGISTRAR'S SIGNATURE Dawson L. Farber							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 of Form 10-5-22-57 et

07164

CERTIFICATE OF DEATH

07139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yr5mthlldys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. STREET ADDRESS 626 N. Fulton Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Mary Last Ennis				4. DATE OF DEATH Month July Day 25 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1881	
9. AGE (In years last birthday) 75 7/8		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Remous Ennie			
14. MOTHER'S MAIDEN NAME Anne Sanders				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11, 1954 , to July 25, 19 57 that I last saw the deceased alive on July 25, 19 57 , and that death occurred at 9:55a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOS.ITAL DATE SIGNED 7-25-57							
ACTUAL SIGNATURE Stella Wachsler M.D.				PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
8-1-57		Old St Pauls.		O'Donnell St. Balto. Md.		Wm Cook/uc. 1217 St. Paul St.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
Wm Cook/uc. 1217 St. Paul St.				AUG 2 '57			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EAU V. S.

3 2 197

REIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07165

Item 2 Film 19-10-5, et

CERTIFICATE OF DEATH

Item 2 Film 19-10-5, et

07140

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVALESCENT HOME		d. STREET ADDRESS (6003 Hunt Club Lane) HUNT CLUB LANE	
3. NAME OF DECEASED (Type or print) First LAURA Middle B Last FARSON		4. DATE OF DEATH Month July Day 26 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY Retired (Nutzler)	11. BIRTHPLACE (State or foreign country) Balto, Md
13. FATHER'S NAME August G Bruckheiser		14. MOTHER'S MAIDEN NAME Catherine Shallenberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-14-4669A	
17. INFORMANT Mrs Eugene Kernan		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHERIOSCLEROTIC C-V DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 MINUTES YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. , 19 54 , to JULY 26 , 19 57 , that I last saw the deceased alive on JULY 10 , 19 57 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Arthur K. Kregina M.D. 1532 HAVENWOOD ROAD			
ACTUAL SIGNATURE Arthur K. Kregina		M.D. 1532 HAVENWOOD ROAD	
PHYSICIAN'S NAME (Type) ARTHUR K. KREGINA M.D.		BALTIMORE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Crema	22b. DATE THEREOF 7-29-57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Ann J. Jenkins		ADDRESS 4905 York Rd	
24a. REC'D BY REGISTRAR DATE 7/29/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

RECEIVED

JUL 30 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07166
CERTIFICATE OF DEATH

07141
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2806 Garnet Road</u>				d. STREET ADDRESS <u>2806 Garnet Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Gertrude E. Callender Fischer</u>				4. DATE OF DEATH Month Day Year <u>July 3rd 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1909</u>	9. AGE (In years last birthday) <u>47</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Evans</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Nickol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Herman P. Fischer, Jr. 2806 Garnet</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>none</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-15-1957</u> to <u>7-2-1957</u> , that I last saw the deceased alive on <u>7-2-1957</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. S. Elliott Harris</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8100 Harford Road, #14 7/3/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. S. Elliott Harris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. C. J. Mason</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1911

RECEIVED

25 - 5 - 12

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25 - 5 - 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07142
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2030 ST. PAUL ST.	
3. NAME OF DECEASED (Type or print) RAYMOND EDGAR FISHER First Middle Last		4. DATE OF DEATH JULY 3 1957 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-18-08 9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR.		10b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER	
11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME UNKNOWN.		14. MOTHER'S MAIDEN NAME MINNIE A. FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 2ND W.W.		16. SOCIAL SECURITY NO. MYRTLE I. DEEDS-2540 GREENMOUNT	
17. INFORMANT MYRTLE I. DEEDS-2540 GREENMOUNT Address AVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FELL INTO WATER WHILE TRYING TO FREE A GROUNDLED BOAT			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 902.4	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE W E. BAERMANN EXAMINER'S NAME (Type) W E. BAERMANN, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/8/57	
22c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL		22d. LOCATION (City, town, or county) (State) FREDERICK RD. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan-3818 Roland Ave		24a. REC'D BY REGISTRAR JUL 5 1957 24b. REGISTRAR'S SIGNATURE Edith H. Hargrett	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

5 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07168

Item 12 11/10/57 cap

07143

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holiday Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 v. 1			
3. NAME OF DECEASED (Type or print) First Herman Middle Fishkin Last Fishkin				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Philip Fishkin				14. MOTHER'S MAIDEN NAME Mitze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Benj. Chamish, 4403 Kennison Ave., Balto.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Arteriosclerotic C-V Disease 6 mos. DUE TO (c) 6 mos.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7-19-57	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-19-57		Mt Carmel		Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis 2100 Eutaw Place				24a. REC'D BY REGISTRAR DATE 22 1957		24b. REGISTRAR'S SIGNATURE Anthony Pirelli	

MEDICAL CERTIFICATION

BUREAU V B

1957

RECEIVED

07169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> b. COUNTY <u>Absecon</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Amacost Home - Regester Ave.</u>				d. STREET ADDRESS <u>Lennox Apts.</u>			
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>FOX</u> Last <u>FOX</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1872</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Koopman</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Robert Fox - 2020 Hanover St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (Bronchial)</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>57</u> , to <u>July 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 4</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.				ADDRESS (Street, city or town, state) <u>2501 York Rd 2/5/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>				DATE SIGNED <u>Townson #4 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto.</u>				24a. REC'D BY REGISTRAR <u>Aug 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Nabel Long</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. D. 1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 17 7-16-57 et

07145

07170

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 Fuller Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. John H. Funk</u>		4. DATE OF DEATH Month Day Year <u>July 6th 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 9, 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William G. Funk</u>		14. MOTHER'S MAIDEN NAME <u>Sarah C. Hudgins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Anna J. Funk, 20 Fuller Ave. #6</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7-8 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/9</u> , 19 <u>51</u> , to <u>7/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/2</u> , 19 <u>57</u> , and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Garis</u> M.D.		ADDRESS (Street, city or town, state) <u>1103 St. Paul Street</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Robert W. Garis</u>		DATE SIGNED <u>7/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hargford Road #14</u>		24a. REC'D BY REGISTRAR <u>10 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. A. L. Ruffenberger</u>	

RECEIVED
JAN 10 1957
U. S. BUREAU

07171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 45yr8mth7dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. (formerly of Catonsville)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.				d. STREET ADDRESS 1809 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK L FURNESS				4. DATE OF DEATH Month Day Year JULY 18 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-78		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Alexander W. Furness CATONSVILLE				14. MOTHER'S MAIDEN NAME CATONSVILLE Miria H. -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 158x Retroperitoneal malignant tumor (Hodgkin's Disease?) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 12 , 19 57 , to July 18 , 19 57 , that I last saw the deceased alive on July 18 , 19 57 , and that death occurred at 3:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-18-57							
ACTUAL SIGNATURE Stella Wachsler		M.D. Stella Wachsler, M. D. Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/22/57	22c. NAME OF CEMETERY OR CREMATORY All Saints Cem.		22d. LOCATION (City, town, or county) (State) Somerset Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons		ADDRESS Baltimore		24a. REC'D REGISTAR DATE JUL 19 57	24b. REGISTRAR'S SIGNATURE W. J. Tucker		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED
JUL 22 1957
BUREAU V. A.

07133

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5172 Viaduct Ave.				d. STREET ADDRESS 5172 Viaduct Ave.			
3. NAME OF DECEASED (Type or print) First MARTHA Middle LILLIAN Last GARLAND				4. DATE OF DEATH Month July Day 14 Year 1957			
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John L. Knode				14. MOTHER'S MAIDEN NAME Virginia C. Spielman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-05-3824		17. INFORMANT Address Mrs. Daisy Moszner-5172 Viaduce Ave., Relay, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conjunctive Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 4, 1957 to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. N. Lederer M.D.				ADDRESS (Street, city or town, state) 1305 Francis Ave.			
PHYSICIAN'S NAME (Type) J. N. Lederer				DATE SIGNED 7/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Com.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE 11 18 1957		24b. REGISTRAR'S SIGNATURE Geo M. Kueffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. S.

07172

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore City		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodbrook Lane		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland	
		f. STREET ADDRESS 119 Greenbrier Road	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Augusta Last German		4. DATE OF DEATH Month July Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1877
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 3 Days — Hours — Min —	11. IF UNDER 24 HRS Hours — Min —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore	
11. BIRTHPLACE (State or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson German		14. MOTHER'S MAIDEN NAME Ann Rebecca Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Robert H. Wheeler - Woodbrook Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma-wide-spread DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of fundus uteri DUE TO (c) Arteriosclerotic cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH More than six months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio-vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 19 57, to July 20, 19 57, that I last saw the deceased alive on July 20, 19 57, and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2919 St. Paul St. Balto. 18, Md. DATE SIGNED			
ACTUAL SIGNATURE Charlotte McCarthy M.D.			
PHYSICIAN'S NAME (Type) Dr. Charlotte McCarthy 2919 St. Paul St. Balto. 18, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/57	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill	22d. LOCATION (City, town, or county) (State) Towson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Mass		24a. REC'D BY REGISTRAR DATE JUL 23 1957	
ADDRESS 805 N. Calvert St.		24b. REGISTRAR'S SIGNATURE Robert H. Wheeler	

BUREAU V. S.

JUL 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 24 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 611 DUNKIN ROAD			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last GILLOTT				4. DATE OF DEATH Month JULY Day 22 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-86		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER			10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM H. GILLOTT				14. MOTHER'S MAIDEN NAME ELIZABETH NORTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) YES 1-18-05 to 8-19-32				16. SOCIAL SECURITY NO. 219-14-0607		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH GIVEN IN PART I. CHR. BRAIN SYNDROME ASSOCIATED WITH ARTERIOSCLEROSIS; PUL. EMPHYSEMA, UNK. DURATION: unknown DURATION: unknown INTERVAL BETWEEN ONSET AND DEATH 3 DAYS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 491x				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 28 , 19 57 , to July 22 , 19 57 , and that death occurred at 8:22 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 7-22-57 ACTUAL SIGNATURE Armen Bogosian M.D. VAH, FORT HOWARD, Maryland 7-22-57 PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN M.D. VAH, FORT HOWARD, Maryland 7-22-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-25-57		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) PIKESVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE SEITZ FUNERAL HOME, 5209 YORK RD. BALTIMORE 12, MD.				24a. REC'D BY REGISTRAR 7/23/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150

Reg. Dist. No.

41

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your own use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1721 Pinewood Drive				d. STREET ADDRESS 1721 Pinewood Drive			
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT WESLEY GOODWIN, SR.				4. DATE OF DEATH Month Day Year July 31 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4,	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Grain		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert Edward Goodwin				14. MOTHER'S MAIDEN NAME Sara Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-8840		17. INFORMANT Address Alice G. Howard 1721 Pinewood Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) HT (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Brooks Bradley				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR 5	
				24b. REGISTRAR'S SIGNATURE M. M. Kelly		DATE 8-1-57	

BUREAU V. S.

116 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07151

07174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutherville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>4310 St Paul St</u>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>B</u> Middle <u>GRAHAM</u> Last				4. DATE OF DEATH <u>July 31</u> Month <u>July</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23, 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Harrisburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Harry Baker</u> (Talker)				14. MOTHER'S MAIDEN NAME <u>Clara Aker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Walter Graham</u> Address <u>3702 Greenway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch pneumonia</u> <u>50.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Alenosa thyroid</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-25</u> , 19 <u>56</u> to <u>present</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>7/26/57</u> , 19 <u>—</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ernest C Brown</u> M.D. <u>1101 N Calvert St-2</u>				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 2 1957</u>		<u>Green Mount</u>		<u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H Jenkins</u> ADDRESS <u>Sono Co 4905 York Rd</u>				24a. REC'D BY REGISTRAR <u>AUG 2 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	

BUREAU V. 2

AUG 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07175

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CV			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 526 GAY STREET			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C Last GREENAGE, JR.				4. DATE OF DEATH Month JULY Day 6 Year 1957			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 25, 1922	
9. AGE (In years last birthday) 34 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10b. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) DENTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM C. GREENAGE, SR.		14. MOTHER'S MAIDEN NAME CORNELIA WHEELER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW-11 213-18-5751		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA LEFT MAXILLARY SINUS WITH GENERALIZED BONE METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 16 , 19 57 , to July 6 , 19 57 , and that death occurred at 1:00 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 7-6-57							
ACTUAL SIGNATURE Chien Wei Lan M.D.				PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH, FORT HOWARD, MARYLAND 7-6-57			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY SPRING GROVE CEMETERY		22d. LOCATION (City, town or county) (State) DENTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R. LAW MORTUARY, 802-OL MADISON AVE.				24a. REC'D BY REGISTRAR DATE July 9, 57		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

RECEIVED

JUL 11 1917

BUREAU V. S.

CERTIFICATE OF DEATH

07153

07176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Montrose Ave.		d. STREET ADDRESS 105 Montrose Ave.	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle GRILL Last GRILL		4. DATE OF DEATH Month July Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 18 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Keiser		14. MOTHER'S MAIDEN NAME Louisa Keebler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruth M. Disney - Dogwood Rd., Woodlawn		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. myocardial Decomensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 12m. 15yr(?)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1957 , to July 18, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Catonsville, Md. DATE SIGNED 7-20-57			
ACTUAL SIGNATURE Walter K. Gallagher M.D.		PHYSICIAN'S NAME (Type) Walter K. Gallagher, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE JUL 23 '57	
24b. REGISTRAR'S SIGNATURE Ellsworth Armacost		24c. REGISTRAR'S SIGNATURE Ellsworth Armacost	

BUREAU V. S.

JUL 20 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07154 45

Reg. Dist. No.

07177

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs</u>				d. STREET ADDRESS <u>Box 534 BAYDRIVE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John M.</u> Middle <u>GUNSAILLUS</u> Last <u></u>				4. DATE OF DEATH Month <u>7</u> Day <u>-25</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1911</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GLENN-MARTIN</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JAMES GUNSAILLUS</u>				14. MOTHER'S MAIDEN NAME <u>PEARL RINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>LORNA GUNSAILLUS</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M B DAVIS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connolly - Essex</u>				ADDRESS <u>1100</u>		24a. REC'D BY REGISTRAR <u>Edith</u>	
				DATE <u>7/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 22 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07155

Reg. Dist. No.

07178

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>11 years</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>24</u> <u>3001.4</u>	
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Edward</u> Last <u>Haines</u>		d. STREET ADDRESS <u>1307 Elina Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1957</u>	5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>6-23-08</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Haines</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret E. Williamson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Records Spring Grove State Hosp.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration Brain temporal lobe</u> DUE TO <u>left (contre coup)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Epileptic Seizure</u> DUE TO (c) <u>C. Central Nervous System Les</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7-2-57</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Convulsive Seizure</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> a. m. <u>6:25</u> p. m. <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Catonsville</u> (County) <u>2</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u> EXAMINER'S NAME (Type) <u>W. E. Mc Grath</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>7/6/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING GROVE STATE HOSP.</u>	22d. LOCATION (City, town, or county) (State) <u>Catonsville 28, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR <u>15 57</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

BUREAU V. 3

1957

RECEIVED
JUN 10 1957

07179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 201 S. Beechfield Ave.	
3. NAME OF DECEASED (Type or print) First Eva Middle Blanche Last Harman		4. DATE OF DEATH Month July Day 17 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Tracey		14. MOTHER'S MAIDEN NAME Elizabeth Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 122.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 9 , 19 57 to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 8:40p M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 7-18-57	
ACTUAL SIGNATURE Stella Wachslar		M.D.	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/20/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Tucker & Sons		24a. REC'D BY REGISTRAR W. J. Tucker	24b. REGISTRAR'S SIGNATURE W. J. Tucker

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07126 Item 1 File 229 8-12-57
CERTIFICATE OF DEATH

07157

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2902 Dunmurry Road</u>		d. STREET ADDRESS <u>2902 Dunmurry Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>26</u> Last <u>Hart</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1885</u> 9. AGE (In years last birthday) <u>72</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Guesman</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Gumpston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Marie Knotts</u> Address <u>2902 Dunmurry</u>			
18. CAUSE OF DEATH [Enter only one cause for one for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7/25/57</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:11</u> P. M. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1957</u> to <u>July 29, 1957</u> that I last saw the deceased alive on <u>July 26, 1957</u> , and that death occurred at <u>6:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>6800 MORNINGTON LN - 7/29/57</u>	
DATE SIGNED <u>7/29/57</u>			
PHYSICIAN'S NAME (Type) <u>M. B. Davis MD</u>		<u>Dundalk - 22nd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>July 30/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reedsville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Reedsville W Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Thomas Home</u>		ADDRESS <u>2112 Dundalk</u>	
24a. REC'D BY REGISTRAR <u>7/30/57</u>		DATE <u>7/30/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>			

RECEIVED
JUL 31 1957
BUREAU V. S.

07180

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 512 Park Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 512 Park Ave.	
3. NAME OF DECEASED (Type or print) First Bertha Middle Cain Last M Hartley		4. DATE OF DEATH Month 7-22 Day 19 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1874
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) practical nurse		10b. KIND OF BUSINESS OR INDUSTRY hospital	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cain		14. MOTHER'S MAIDEN NAME Elizabeth Stocksdales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT M. Bremer Shearman, Sr., 512 Park Ave., Towson 4, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis (c) 4 years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1936 to July 22 1957 that I last saw the deceased alive on July 22 1957 and that death occurred at 2 P M , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Charles H. Reier M.D. 6701 York Rd Balto 12		md 23 July 1957	
PHYSICIAN'S NAME (Type) Charles H. Reier			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-57	22c. NAME OF CEMETERY OR CREMATORY Friends Burial Grounds	22d. LOCATION (City, town, or county) (State) 2506 Harford Rd., Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brown		ADDRESS Brooks Funeral Service 622 York Rd., Towson 4, Md	
24a. REC'D BY REGISTRAR July 23, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 25 1957

U. S. BUREAU OF INVESTIGATION

1 M 14 I VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 M 14 I VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07181

CERTIFICATE OF DEATH

07159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1yrlmth5dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1866</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Issac Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 11, 1956</u> , to <u>7-7, 1957</u> , that I last saw the deceased alive on <u>7-6, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Frank J. Connelly</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOHN VASCONCELLOS</u> <u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Nanjemoy Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

BUREAU V. S.

JUL 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07182

CERTIFICATE OF DEATH

07160

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1500 CLIFTON AVE.			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E Last HENSON				4. DATE OF DEATH Month JULY Day 19 Year 1957			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 5, 1922	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RADIO REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY RADIO REPAIR SHOP		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES HENSON				14. MOTHER'S MAIDEN NAME LOUISE BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 217-16-1236		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 5810 DUE TO CIRRHOSIS OF THE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5½ YEARS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 202x						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JULY 18 , 19 57 , to JULY 19 , 19 57 . that he was deceased and that death occurred at 10:25 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD DATE SIGNED 7/19/57 ACTUAL SIGNATURE Chien Wei Lan M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Balto. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802-04 Madison Ave Balto. 1, Md				24a. REC'D BY REGISTRAR 23 1957 REGISTRAR'S SIGNATURE Lawson L. Garber			

BUREAU V. S.

111 09 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 5 111 218 7-31-57 et 07183 CERTIFICATE OF DEATH

07162

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 53 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Aigburth Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH FORBES SHAW HERGENRATHER				4. DATE OF DEATH Month Day Year July 4, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 Sept. 15, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Ford Shaw				14. MOTHER'S MAIDEN NAME Jane Elizabeth Forbes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF ORIS 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANEMIA, Secondary DUE TO (c) MALIGNANCY, Undetermined site						INTERVAL BETWEEN ONSET AND DEATH 10 days 1 year. 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420 ARTERIOSCLEROTIC HEART DISEASE.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) ONE			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NO			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from January, 1956 , to July 4, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A.S. Chalfant M.D. 6210 York Rd July 5, 1957 PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR July 5, 1957	
				24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

BOREAU V. B.

1057 8 10

1057 8 10

07184

CERTIFICATE OF DEATH

07163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2132 Rockwell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First REBECCA Middle M. Last HOENES		4. DATE OF DEATH Month July Day 1 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1892
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Tory		14. MOTHER'S MAIDEN NAME Clara -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. D. A. Nolker-3215 B Terrace Drive, Wash.		Address D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Inanition due to excision of greater portion 5702 DUE TO of small intestine because of thrombosis of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) superior mesenteric artery. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic vascular disease 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 19 57 , to July 1, 19 57 , that I last saw the deceased alive on July 1, 19 57 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Knipp M.D.		ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED July 3, 1957	
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		Baltimore 29, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/57	22c. NAME OF CEMETERY OR CREMATORY Western Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tietner & Sons - Balt.		24a. REC'D BY REGISTRAR DATE JUL 9 '57 24b. REGISTRAR'S SIGNATURE Wm. J. Tietner	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 5 1957

RECEIVED

07185

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural: Towson	LENGTH OF STAY (in this place) 1 month	CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Phoenix, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudwood Sanatorium Towson 4, Maryland		STREET ADDRESS Paper Mill Rd.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) John	(Middle) Martin	(Last) Hoffman	(Date) 7 (Month) 2 (Day) 19 57 (Year)
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Wid.	8. AGE last birthday: 73 yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Welder		10b. KIND OF BUSINESS OR INDUSTRY: Quarry	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: Chris Hoffman		14. MOTHER'S MAIDEN NAME: Annie Ledley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudwood Sanatorium	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		6 mos.
Immediate cause (a) Pulmonary Tuberculosis		
Antecedent causes (s) (b) ...		
(c) ...		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		HOMICIDE	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from 5-30, 1957, to July 2, 1957, that I last saw the deceased alive on July 2, 1957, and that death occurred at 9:25 PM from the causes and on the date stated above.			
SIGNATURE Milton B. Kuss M.D.		ADDRESS Eudwood Sanatorium - Towson 4, Maryland	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
Burial		7-5-57	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Grace Methodist		Cockeysville Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
July 3, 1957		Mabel C. Gray	
24. FUNERAL DIRECTOR		ADDRESS	
Brooks Funeral Service		622 York Rd. Towson 4, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 9 1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07127 Items 5&6 Film 0218 7/26/57 cap

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8213 BEAR CREEK DR.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u> d. STREET ADDRESS <u>8213 BEAR CREEK DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DANIEL WASHINGTON HUFHAM</u> First Middle Last 4. DATE OF DEATH <u>7-18-</u> <u>1957</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JULY 22, 1895</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>61</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE MFG.</u> 11. BIRTHPLACE (State or foreign country) <u>N.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>NOAH HUFHAM</u> 14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>21-05-34</u> 17. INFORMANT <u>MR. V. F. HUFHAM</u> Address <u>STATE</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAUSE OF LUNG - RT</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>18 MCL</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>UNK</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis M.D.</u> EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>7/22/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH LANE</u>				22d. LOCATION (City, town, or county) (State) <u>BALTO. Co. MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Kelly</u> ADDRESS <u>1000 North Broadway, Dundalk, Md.</u>				24a. REC'D BY REGISTRAR <u>John Kelly</u> 24b. REGISTRAR'S SIGNATURE <u>John Kelly</u> DATE <u>JUL 22 1957</u>			

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JUL 22 1957
BUREAU V. S.

07186

CERTIFICATE OF DEATH

07166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>105 Fairfield Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY VIRGINIA HUNDLEY</u>		4. DATE OF DEATH <u>July 14 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-9-1880</u>
9. AGE (In years at birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BEN FISHER</u>		14. MOTHER'S MAIDEN NAME <u>THEODOGIA RICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Boulsh E. Headley</u>		Address <u>105 Fairfield Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene Lower Extremity left.</u> DUE TO (b) <u>Arterio sclerosis obliterans.</u> DUE TO (c) <u>Degenerative Heart Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 12 1957</u> to <u>July 14 1957</u> that I last saw the deceased alive on <u>July 12 1957</u> and that death occurred at <u>1303 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.E. Mc Grath</u>		DATE SIGNED <u>7/14/57</u>	
PHYSICIAN'S NAME (Type) <u>W.E. Mc Grath</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28nd</u>	
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coan Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Heathsville Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Garfel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. RECEIVED BY REGISTRAR <u>Jul 15 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1 15 1957

BUREAU V. S.

07187

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>19 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Enoch Pratt Hospital</u>				e. STREET ADDRESS <u>Greenway Apts. Charles + 34th St.</u>			
3. NAME OF DECEASED (Type or print) <u>DR. GUY LE ROY HUNNER</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1868</u>	9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OB-GYN Practice</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John HUNNER</u>			
14. MOTHER'S MAIDEN NAME <u>Eudora Cooke</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NO</u>				17. INFORMANT <u>MRS. G. L. HUNNER (wife)</u> Address <u>Greenway Apts Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Inf. Vena Cava thrombosis</u> DUE TO (c) <u>metastatic Ca - liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>/</u>			
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u>	
20f. (City or town) <u>/</u>				20g. (County) <u>/</u>		20h. (State) <u>/</u>	
21. I certify that I attended the deceased from <u>12-26, 1955</u> to <u>7-14, 1957</u> , that I last saw the deceased alive on <u>7-14, 1957</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard Fisch</u>				ADDRESS (Street, city or town, state) <u>M.D. 1216 John St. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard Fisch</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 16, 1957</u>		22c. NAME OF GEMETRY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins + Sons, Co.</u>				ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR <u>Mabel Gump</u>	
24b. REGISTRAR'S SIGNATURE <u>Mabel Gump</u>				DATE <u>JUL 18 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 18 1957
BUREAU V. S.

07188

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8910 Emla Ave.</u>				d. STREET ADDRESS <u>8910 Emla Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF <u>Ernest</u> First Middle Last				4. DATE OF DEATH <u>July 12 1957</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Sander - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ernest Jaeger</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Bast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-76-8604</u>		17. INFORMANT <u>Carroll Jaeger</u>		Address <u>8910 Emla Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>Arteriosclerosis Coronary</u> <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Age</u> (c) <u>Age</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>55</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>57</u> , and that death occurred at <u>2:39 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd., Baltimore 14, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank T. Kasik, Jr.</u>				DATE SIGNED <u>7/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loasahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. S.

07189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Id.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>XO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u> <u>301 Chesapeake Ave.</u>				d. STREET ADDRESS <u>216 Murdock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MAY</u> Last <u>JUNG</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker (rtd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>							
13. FATHER'S NAME <u>David Keller</u>				14. MOTHER'S MAIDEN NAME <u>Susan —</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Lillian Batzer - 216 Murdock Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Decompensative Cardio Vascular Disease</u> <u>443X</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5, 1955</u> to <u>July 9, 1957</u> , that I last saw the deceased alive on <u>July 9, 1957</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post M.D.</u>				ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u>		DATE SIGNED <u>7-11-57</u>	
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schaefer & Sons - Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

RECEIVED
JUL 10 1957
BUREAU V. S.

07190

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH July 30, 1957

1. NAME OF DECEASED
(Type or Print)

Charles E. Kellogg

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore County

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4516 Forestview Ave4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore (Overlea) XD. STREET ADDRESS (If rural, give location)
4516 Forestview Ave

C. Length of stay in Baltimore

5 SEX

Male

6 COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

3/24/1922

9. AGE (In years last birthday)

65

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk10B. KIND OF BUSINESS OR INDUSTRY
Glenn L Martin11. BIRTHPLACE (State or foreign country)
Baltimore, Md12. CITIZEN OF WHAT COUNTRY?
U.S13. FATHER'S NAME
Theodore Kellogg14. MOTHER'S MAIDEN NAME
Laura Neal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Myrtle E Kellogg, 4516 Forestview

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
DUE TO

(A) acute myocardial infarction 1/2 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(B) chr. coronary sclerosis 25 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/30 1957 to 4/1 1933, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☒MED. DIRECTOR ☐STAFF PHYS. ☐

M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

8/31/57

24C. NAME OF CEMETERY OR CREMATORY

Pawwood cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY LOCAL HEALTH DEPT.

REGISTERING SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

AUG 1 1957

AUG 8 1957

J. Ruck, 5305 Harford Rd

PLEASE TYPE, OR WITH PERMANENT RECORD, THIS IS A PERMANENT RECORD. DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and legibly. CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.

BUREAU V. B.

JUG 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07191

CERTIFICATE OF DEATH

07171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>2915 Joppa Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Krause</u>				4. DATE OF DEATH Month Day Year <u>July 31 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 4 1867</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>August Lowensen</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr Louis A M Krause 2619 Joppa Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio vascular disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with pneumonia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>0 MO. 1 HS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>July 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>57</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lester A. Wall, Jr.</u>				ADDRESS (Street, city or town, state) <u>1039 St. Paul Street Baltimore, Maryland</u>		DATE SIGNED <u>8/1/57</u>	
PHYSICIAN'S NAME (Type) <u>Lester A. Wall, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Aug 3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u>				ADDRESS <u>4210 Belair Road</u>		24a. REC'D BY REGISTRAR DATE <u>8/5/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Peacock</u>			

BUREAU V. S.

AUG 21

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07172

07192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Castle Drive				d. STREET ADDRESS 504 Castle Drive			
3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Kriechbaum				4. DATE OF DEATH Month July Day 3, Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1881		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Casmir B. Kriechbaum				14. MOTHER'S MAIDEN NAME Lucy B. Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clara W. Kriechbaum Address 504 Castle Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Cancer of Sigmoid Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Colon. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mos ? 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1956 to July 3, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 6:24 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6702 Park Heights Ave. DATE SIGNED							
ACTUAL SIGNATURE Jonas H. Cohen M.D.				DATE SIGNED July 9 57 Clara W. Kriechbaum			
PHYSICIAN'S NAME (Type) JONAS H. COHEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR DATE 9 57			
				24b. REGISTRAR'S SIGNATURE Clara W. Kriechbaum			

BUREAU V. 3

JUL 8 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07173

CERTIFICATE OF DEATH

Reg. Dist. No.

07193

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>				STREET ADDRESS (If rural, give location) <u>4702 Delaware Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Alexius Elder Kreis</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>7</u> (Year) <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Oct. 23, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Month <u>7</u> Days <u>7</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Retired Attendant American Oil Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Kreis</u>				14. MOTHER'S MAIDEN NAME <u>Florilla Ann Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215-09-0081</u>		17. INFORMANT & ADDRESS <u>William C. Mara 2727 Ave</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>THROMBOSIS, CEREBRAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROSIS GEN'L.</u>						<u>15 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at not <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2, 1957</u> , to <u>July 7, 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>5:25 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John F. Sharkey</u> M.D.				ADDRESS (Street, city, town, state) <u>401 RANDOM-BALTO. 29 MD.</u>		DATE SIGNED <u>7/9/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 10, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 16 57</u>		REGISTRAR'S SIGNATURE <u>John F. Sharkey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foring Gyere</u>		ADDRESS <u>5005 Pk 1st St Balto 15 Md.</u>	

BUREAU V. S.

RECEIVED
JUL 12 1901

07194

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Balt.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x. Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3007 Woodside Ave</i>		d. STREET ADDRESS <i>3007 Woodside Ave</i>	
3. NAME OF DECEASED (Type or print) <i>John J. Kuhn</i> First Middle Last		4. DATE OF DEATH <i>July 29</i> Month Day Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/27/196</i>
9. AGE (In years last birthday) <i>67</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Coverer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Joseph J. Kuhn</i>	
14. MOTHER'S MAIDEN NAME <i>Josephine Kern</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Louisa Kuhn, 3007 Woodside Ave</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute CORONARY Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYPERTENSIVE-ARTERIOSCLEROTIC-C.T.D</i> DUE TO (c) <i>15 MINS</i> <i>10 YRS.</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April, 1948</i> to <i>July 29, 1957</i> that I last saw the deceased alive on <i>July 22, 1957</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Albert J. Himelfarb</i> M.D.		ADDRESS (Street, city or town, state) <i>3501 ST. Paul ST. Balto -18. Md.</i> DATE SIGNED <i>7/30/57</i>	
PHYSICIAN'S NAME (Type) <i>ALBERT J. HIMELFARB</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 2, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i> ADDRESS <i>5305 Hargford Rd.</i>		24a. REC'D BY REGISTRAR <i>JUL 31 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. R. M. Brown</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 31 1957

BUREAU V. S.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												07175	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												07195	
Reg. Dist. No. 38													
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>2yrs3mths</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ARMA COST NURSING HOME</u>				d. STREET ADDRESS <u>620 S. Washington St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ADAM KUPIDLOWSKI</u>				4. DATE OF DEATH <u>7 6 19 57</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13, 1911</u>		9. AGE (In years, months, days) <u>45 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvage Corpsman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Ins. Sal</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Wladyslaw Kupidlowski</u>				14. MOTHER'S MAIDEN NAME <u>Michalina Filipak</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO. <u>yes</u>				17. INFORMANT <u>John Kupidlowski</u> Address <u>912 N. Streeper St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Craniac Cerebral Injury</u> <u>960X</u> <u>MASSIVE GASTRIC INTESTINAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MASSIVE GASTRIC INTESTINAL HEMORRHAGE</u> DUE TO (c) <u>MASSIVE GASTRIC INTESTINAL HEMORRHAGE</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Salvage truck and Fire truck collision</u>									
20c. TIME OF INJURY Month, Day, Year <u>4/18/57</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>				20f. (City or town) (County) (State) <u>Baltimore & Caroline Sts. Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>William Upjohn</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7-7-57</u>					
EXAMINER'S NAME (Type) <u>John A. Moran</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>July 10, 1957</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemt.</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>				ADDRESS <u>3000 E. Baltimore St.</u>				24a. REC'D BY REGISTRAR <u>JUL 9 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Walter Gray</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07128

CERTIFICATE OF DEATH

07176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>105 Baltimore Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Lairnie</u> Last <u>Lairnie</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Allyander Lairnie</u>				14. MOTHER'S MAIDEN NAME <u>Jane Rodger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marion Koran</u> Address <u>2837 Dunbar Ct</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio sclerosis.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-17</u> , 19 <u>57</u> , to <u>7-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-4</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene F. Nery</u> M.D.				ADDRESS (Street, city or town, state) <u>7001 Mornington Rd Dundalk 22, Md</u>			
DATE SIGNED <u>July 6 1957</u>							
PHYSICIAN'S NAME (Type) <u>Eugene F. Nery</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 6 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u> ADDRESS <u>2112 Dundalk</u>				24a. REC'D BY REGISTRAR <u>5</u> DATE <u>5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>	

BUREAU V. S.

JUL 8 1957

RECEIVED

07196

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. LENGTH OF STAY IN 1b 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3611 Langrehr Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Lammers Last Lammers		4. DATE OF DEATH Month July Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min 87	IF UNDER 24 HRS. Months 87 Days 87 Hours 87 Min 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY one who did	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Henry Schotlich		14. MOTHER'S MAIDEN NAME Pauline Hentchel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dr. Walter J. Lammers		Address 417 Hollen Rd. (12)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Advanced arteriosclerosis DUE TO (c) Advanced arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH about 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 to July 9, 1957 that I last saw the deceased alive on July 7, 1957 and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David S. Kibbett		M.D. 4508 N. Charles St DATE SIGNED 7/10/57	
PHYSICIAN'S NAME (Type) David S. Kibbett		Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-1957	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W North Ave	
24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JUL 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

C7197

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN IB 88 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TYASKIN			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle L. Last LARMORE				4. DATE OF DEATH Month JULY Day 28 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-95	
9. AGE (In years last birthday) 62 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11. BIRTHPLACE (State or foreign country) TYASKIN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. LARMORE				14. MOTHER'S MAIDEN NAME GARNETTA DICKERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) YES WW-1				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO CIRRHOSIS OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 11 DAYS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYELONEPHRITIS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that VA attended the deceased from MAY 1 , 19 57 , to JULY 28 , 19 57 , and that death occurred at 9:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 7-28-57							
ACTUAL SIGNATURE Harold R. Johnson M.D.							
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON				M.D. VAH, FORT HOWARD, MARYLAND 7-28-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-57		22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) TYASKIN, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE C.G. MESSICK				ADDRESS TYASKIN, MARYLAND		24a. REC'D BY REGISTRAR 30 1957	
				24b. REGISTRAR'S SIGNATURE <i>Lawson L. Taylor</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 30 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3-5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07198

CERTIFICATE OF DEATH

07179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 57 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LEONARD Last				4. DATE OF DEATH Month JULY Day 13 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1 1889	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Florence, Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Grinder				10b. KIND OF BUSINESS OR INDUSTRY Western Elec. Co.			
13. FATHER'S NAME Thomas Leonard				14. MOTHER'S MAIDEN NAME Amanda Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 160-07-2388			
17. INFORMANT Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL EXSANGUINATION 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CA OF PANCREAS WITH METASTASES DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of Prostate							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from May 17 , 19 57 , to July 13 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 7/13/57							
ACTUAL SIGNATURE W. DUDLEY, MD.				M.D. Veterans Administration Hospital			
PHYSICIAN'S NAME (Type) W. DUDLEY, MD.				Fort Howard, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7/18/57	
				24b. REGISTRAR'S SIGNATURE L. Fisher			

U.S. AIR

1954

7.11

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07199

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bellona Avenue		d. STREET ADDRESS Bellona Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA E. LEWIS		4. DATE OF DEATH Month July Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1867
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Single maiden		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Simon P. Lewis		14. MOTHER'S MAIDEN NAME Harriett Keggria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. C. W. Amos, Bellona Ave., Ruxton 4, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 weeks many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1957 to July 7, 1957 that I last saw the deceased alive on July 3, 1957 , and that death occurred at 8 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Franklin E. Leslie M.D. 2929 N. Charles St. - Balto 18, Md.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery	22d. LOCATION (City, town, or county) (State) Everett, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro		ADDRESS Towson, Maryland	24a. REC'D BY REGISTRAR July 8, 1957
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07200

CERTIFICATE OF DEATH

07181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle (Alpheus) Last A. LEWIS				4. DATE OF DEATH Month July Day 25 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/88	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Maker		10b. KIND OF BUSINESS OR INDUSTRY Rubber Plant		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert John Lewis				14. MOTHER'S MAIDEN NAME Ann Francis Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 213-05-8098A		17. INFORMANT Address Clint/Rac.Vets.Admin.Hospital,Fort Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X METASTATIC CARCINOMA TO BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 527.2 (b) CARCINOMA OF LUNG RIGHT. POST OPERATIVE DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonectomy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from July 12 , 19 57 , to July 25 , 19 57 . and that death occurred at 3:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 7/25/57							
ACTUAL SIGNATURE T. Lawrence Fleisher M.D.							
PHYSICIAN'S NAME (Type) T. LAWRENCE FLEISHER, M.D. Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/27/57	22c. NAME OF CEMETERY OR CREMATORY Mount Hebron Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE William Tickner & Sons			24a. REC'D BY REGISTRAR 7/27/57	24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

William Tickner & Sons, Inc, North & Pennsylvania Aves, Balto., Md.

RECEIVED
JUL 1 1944
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

071825

07201

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. county</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1642 Rickenbacker Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William W. Lingenfelder</u>				4. DATE OF DEATH <u>July 30 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 30, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Attorney - Retired</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry F. Lingenfelder</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Paris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Laura Lingenfelder 1642 Rickenbacker Rd. (21)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/29/57</u> , 19 <u>57</u> , to <u>7/30/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 30</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. White</u>				ADDRESS (Street, city or town, state) <u>4223 Eastern Ave Baltimore 21, Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>moreland memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Aug 5 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith H. Hurler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 11 1911

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07183

07202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 39 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIS LONG, JR.				4. DATE OF DEATH Month Day Year July 2 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 29, 1916	9. AGE (In years last birthday) yrs. 40	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willis Long, Sr.				14. MOTHER'S MAIDEN NAME Edna Kirkwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1992 ADENOCARCINOMA, JUNCTION OF ESOPHAGUS AND CARDIAC OF STOMACH, WITH GENERALIZED METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VA HOSPITAL, FORT HOWARD, MARYLAND		(County) (State)	
21. I certify that I attended the deceased from May 24, 19 57 , to July 2, 19 57 and that death occurred at 4:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 7/2/57							
ACTUAL SIGNATURE Chien Wei Lan M.D. VA HOSPITAL, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-7-57	22c. NAME OF CEMETERY OR CREMATORY Tindley's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Somerset County, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Savage Funeral Home, New Church, Virginia				24. RECEIVED BY REGISTRAR JUL 9 1957			
25. REGISTRAR'S SIGNATURE Lawson L. Fisher							

STANDARD

JUL 9 1957

RECEIVED

7203

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2721 Maple Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle E Last LORD		4. DATE OF DEATH Month July Day 27 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14-1865
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Bg Hs Md	
11. BIRTHPLACE (State or foreign country) Bg Hs Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HENRY Nagel		14. MOTHER'S MAIDEN NAME Elizabeth Worth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mamie Watkins		Address 2721 Maple Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASCV Disease, Cardiovascular collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 571.1 Dementia, Rehydrated		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None.	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/20 , 19 57 , to 7/27 , 19 57 , that I last saw the deceased alive on 7/27 , 19 57 , and that death occurred at 8:30 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W Thomas Lloyd M.D.			
PHYSICIAN'S NAME (Type) William Thomas Lloyd			
22a. BURIAL, CREMATION, (Specify)	22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town or county) (State) Bg Hs Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc		ADDRESS 1305 Harford Rd	
24a. REC'D BY REGISTRAR JUL 30 1957		24b. REGISTRAR'S SIGNATURE Dr. M. D. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 30 1957

BUREAU V. S.

07204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u> <u>301 West Chesapeake Avenue</u>				d. STREET ADDRESS <u>1201 East North Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>E.</u> Last <u>Lotterer</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1893</u>	
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Keyes</u>				14. MOTHER'S MAIDEN NAME <u>Nancy E. Hepbrun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>J. Edwin Scoggins, 1205 East North Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon & General</u> <u>153x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>29 Oct., 1954</u> to <u>11 July, 1957</u> , that I last saw the deceased alive on <u>11 July, 1957</u> , and that death occurred at <u>220 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas W Edmonds</u> M.D.				ADDRESS (Street, city or town, state) <u>2746 The Alameda Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>Chas. W Edmonds</u>				DATE SIGNED <u>12 July 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Guy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07205
CERTIFICATE OF DEATH

07186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mth25days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elfrieda Middle Umbach Last Lotz				4. DATE OF DEATH Month July Day 2 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1885	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Henry Umbach				14. MOTHER'S MAIDEN NAME Katherine Doering			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c.)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial degeneration with hypertrophy DUE TO Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3 , 19 57 , to July 2 , 19 57 , that I last saw the deceased alive on July 2 , 19 57 , and that death occurred at 7:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louie Frances Woodward				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-2-57			
PHYSICIAN'S NAME (Type) Louie Frances Woodward, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF July 5, 1957		22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md	
23. FUNERAL DIRECTOR'S SIGNATURE T. Swab (Type)				ADDRESS Louie Frances Woodward		24a. REC'D BY REGISTRAR DATE 7-2-57	
				24b. REGISTRAR'S SIGNATURE Q. C. C. C.			

BUREAU V. E.

JUL 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 will be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07206

CERTIFICATE OF DEATH

07187

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.				c. LENGTH OF STAY IN TB 1 Hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1424 W. PRATT STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMOS Middle R. Last MACE				4. DATE OF DEATH Month July Day 10 Year 1957							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1923		9. AGE (In years last birthday) yrs. 33			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company		11. BIRTHPLACE (State or foreign country) Frost, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jacob Mace				14. MOTHER'S MAIDEN NAME Minnie Kelley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO 217-24-0034		17. INFORMANT Clin. Rec., Vet Adm Hosp, Ft. Howard, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 10, 12:15 PM 1957 to July 10, 1957 and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND DATE SIGNED 7/11/57 ACTUAL SIGNATURE Irving Freeman M.D. IRVING FREEMAN, M.D., Chief, Medical Service											
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist Church		22d. LOCATION (City, town, or county) (State) Freeland, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc. ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 28, Md.						24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Dr. Dances Parley			

VS A15 (4)
15M 9/55
Shipped:
By Hearse By

RECEIVED

JUL 15 19

BUREAU V. S.

07207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Glencoe Road</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general maints.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Goodwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-321303</u>		17. INFORMANT <u>Charles E. Martin</u>		Address <u>Glencoe</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 11, 1957</u> , to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Coopersville, Md.</u> DATE SIGNED <u>Elizabeth B. Sherwill</u>							
ACTUAL SIGNATURE <u>Elizabeth B. Sherwill</u> M.D. <u>Coopersville, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherwill MD Coopersville Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Scott Brooks, 672 York Rd, Towson, Md.</u>							
24a. REC'D BY REGISTRAR <u>Elyzabeth Grouchy</u>				24b. REGISTRAR'S SIGNATURE <u>Elyzabeth Grouchy</u>			
DATE <u>JUL 22 1957</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

07129

CERTIFICATE OF DEATH 07189

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b Dundalk, 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Woodland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Stephen Martin		4. DATE OF DEATH Month Day Year July 16 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1885
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Bethlehem Steel	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Sterling, 15 Woodland Ave, Dundalk 22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs-
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1957, to July 16, 1957, that I last saw the deceased alive on July 16, 1957, and that death occurred at 7:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 16800 Morningstar Rd - 7/18/57			
ACTUAL SIGNATURE M. B. Davis M.D.		DATE SIGNED 7/18/57	
PHYSICIAN'S NAME (Type) M. B. Davis M.D.		Dundalk - Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-20-57	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	22d. LOCATION (City, town, or county) (State) Dundalk 22, Md
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE 22 1957	
		24b. REGISTRAR'S SIGNATURE Thos. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 22 1957
BUREAU V. A.

07208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Ed. D. 4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7102 York Rd.				d. STREET ADDRESS 7803 Oakdale Ave.			
3. NAME OF DECEASED (Type or print) First CORA Middle MAY Last MASON				4. DATE OF DEATH Month July Day 21 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse			10b. KIND OF BUSINESS OR INDUSTRY private duty		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Bion H. Mitchell				14. MOTHER'S MAIDEN NAME Helen Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-4396		17. INFORMANT Address Mrs. Geo. Seward - 7102 York Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Metastatic Carcinoma of liver DUE TO Primary carcinoma of breast. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 mos. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 156.1							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 57 , to July , 19 57 , that I last saw the deceased alive on 7-21 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred G. Ossman, Jr. M.D.				ADDRESS (Street, city or town, state) 1101 St. Paul St. Balto. Md.			
PHYSICIAN'S NAME (Type) Alfred G. Ossman, Jr. M.D.				DATE SIGNED 7-24-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/47		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Liseney & Sons - Balto				24a. REC'D BY REGISTRAR DATE 7/24/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

BUREAU V. 1

JUL 25 1957

RECEIVED

07209

CERTIFICATE OF DEATH

07191 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO Co. MD MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD</u> b COUNTY <u>BALTO Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3325 Willoughby RD</u>		d. STREET ADDRESS <u>3325 Willoughby RD</u>	
3. NAME OF DECEASED (Type or print) <u>WILBERT H. MATTES</u>		4. DATE OF DEATH <u>July 31, 1957</u>	
5. SEX <u>MA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 1, 1911</u>
9. AGE (In years, last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>HERMAN MATTES</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE MOLLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-7696</u>	
17. INFORMANT <u>MRS W. H. MATTES</u>		Address <u>3325 Willoughby RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sinus & widespread metastasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/29</u> to <u>7/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>57</u> , and that death occurred at <u>8:00 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Thomas Lloyd</u>		ADDRESS (Street, city or town, State) <u>9005 Hartford Rd</u>	
PHYSICIAN'S NAME (Type) <u>William Thomas Lloyd</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>8/3/57</u>	<u>St. John Evan Luth Cem</u>	<u>BALTO Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Crane</u>		24a. REC'D BY REGISTRAR <u>AUG 2 1957</u>	
ADDRESS <u>8802 Bayview Pl</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

JUG 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07192

07210

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (Rural)		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quaker Bottom Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irving Waugh Matthews		4. DATE OF DEATH July 2 1957	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-18-1900	
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner, operator		10b. KIND OF BUSINESS OR INDUSTRY real estate	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry A. Matthews		14. MOTHER'S MAIDEN NAME Dora Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-26-9577	
17. INFORMANT Margaret Matthews, Sparks, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1957 , to July 2, 1957 , that I last saw the deceased alive on July 2, 1957 , and that death occurred at 2:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) PARKTON, Md DATE SIGNED 7/2/57 ACTUAL SIGNATURE G. M. France M.D. P. R. K. TON, Md PHYSICIAN'S NAME (Type) A. M. FRANCE			
22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		22b. DATE THEREOF 7-5-57	
22c. NAME OF CEMETERY OR CREMATORY Friends Meeting		22d. LOCATION (City, town, or county) (State) Sparks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service J. Scott Brooks		24a. REC'D BY REGISTRAR JUL 8 1957	
ADDRESS 622 York Rd. Towson 4, Md.		24b. REGISTRAR'S SIGNATURE Ely Branch	

BAU V. B.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07211

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md. c. LENGTH OF STAY IN 1b MAURER d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 2314 SIDNEY AVENUE, BALTO 30 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle MAURER Last MAURER		4. DATE OF DEATH Month 7 Day 26 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 7 Hours 26 Min. 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY GEORGE CO.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD MAURER		14. MOTHER'S MAIDEN NAME THERESA RITTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0120 (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TUBERCULOSIS OF THORACIC AND LUMBAR SPINE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 5-1 , 19 57 , to 7-26 , 19 57 , that I last saw the deceased alive on 7-26 , 19 57 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED	22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORY London Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE W. C. C. Funeral Home		24a. REC'D BY REGISTRAR DATE _____	24b. REGISTRAR'S SIGNATURE Joseph R. R. R.

RECEIVED

JUL 29 1967

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07212

CERTIFICATE OF DEATH

Reg. Dist. No.

07194

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr11mth14dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Linthicum, Maryland		d. STREET ADDRESS Linthicum, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Peter Francis Maxa		4. DATE OF DEATH Month Day Year July 4 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1871
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pilsen, Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-2-57			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 19 57 , to July 4, 19 57 , that I last saw the deceased alive on July 4, 19 57 , and that death occurred at 7:50am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslar M.D. SPRING GROVE STATE HOSPITAL 7-4-57			
ACTUAL SIGNATURE Stella Wachslar		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McJully Funeral Homes		24a. REC'D BY REGISTRAR JUL 8 '57	
ADDRESS 130 E. Fort Ave. #30		24b. REGISTRAR'S SIGNATURE W. H. Search	

BUREAU V. S.

JUL 2 1957

RECEIVED

07213

CERTIFICATE OF DEATH

07195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE				d. STREET ADDRESS 1917 DUNDALK AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SARAH BELLE Mc CAFFEY				4. DATE OF DEATH Month Day Year 7 - 7 - 1957			
5. SEX FEM.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-20-1886	
9. AGE (In years last birthday) 80 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN (ret)		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT LITTLE		14. MOTHER'S MAIDEN NAME ELIZABETH HAMILTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-12-1536		17. INFORMANT ELIZABETH KNIGHT Address 1917 Dundalk Ave. Balt 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic coronary thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes melitus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes melitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-7-1957 , to 7-7-1957 , that I last saw the deceased alive on 7-7-1957 , and that death occurred at 4:55 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas M.D.				ADDRESS (Street, city or town, state) Spring Grove St. Hoip. DATE SIGNED 7/7/57			
PHYSICIAN'S NAME (Type) Bruno RADAUSKAS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/57		22c. NAME OF CEMETERY OR CREMATORY Darlington Cem.		22d. LOCATION (City, town, or county) (State) Darlington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner ADDRESS 17 Md.				24a. REC'D BY REGISTRAR JUL 10 1957		24b. REGISTRAR'S SIGNATURE Wm. J. Tickner	

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BUREAU V. 3

JUL 10 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07214

CERTIFICATE OF DEATH

07196 47

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
c. LENGTH OF STAY IN 1b <u>17 yrs.</u>				d. STREET ADDRESS <u>5-231 Trumps Mill Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5-231 Trumps Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Katherine M. McCann</u>				4. DATE OF DEATH <u>July 6 1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 14 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milner Hotzler Co. Milner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ypsilanti Mich</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James McCann</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Jane Smith</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT <u>Anna B. Schuster</u> Address <u>5231 Trumps Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic vascular disease</u>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 12, 1957</u> to <u>July 6, 1957</u> , that I last saw the deceased alive on <u>July 2, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard R. Rigler</u> M.D.				ADDRESS (Street, city or town, state) <u>1 W. OVERLEA AVE 7117</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD R. RIGLER</u>				DATE SIGNED <u>July 6, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald B. 7110 Belair Rd.</u>				24a. REC'D. BY REGISTRAR <u>JUL 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Reford</u>	

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07197

07215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 CHURCH LANE		d. STREET ADDRESS 9 CHURCH LANE	
3. NAME OF DECEASED (Type or print) KATHERINE ECKENRODE McKIM		4. DATE OF DEATH July 31, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1869
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) ADAMS CO. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ECKENRODE		14. MOTHER'S MAIDEN NAME MARIA CLUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. KATHERINE CHALMERS		Address Pikesville, CHURCH LANE Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 12, 1957 to July 30, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Waverly S. Green Jr. M.D.		ADDRESS (Street, city or town, state) Pikesville 8, Md	
PHYSICIAN'S NAME (Type) Waverly S. Green Jr., M.D.		DATE SIGNED Aug 1, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-3-57	22c. NAME OF CEMETERY OR CREMATORY ST. CHARLES	22d. LOCATION (City, town, or county) (State) PIKESVILLE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Newell		ADDRESS Pikesville, Md	
24a. REC'D BY REGISTRAR Aug 5 1957		24b. REGISTRAR'S SIGNATURE Anthony Newell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07216

CERTIFICATE OF DEATH

Reg. Dist. No.

07198

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 392 Butler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle J. Last Merkel		4. DATE OF DEATH Month July Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1915
9. AGE (In years, last birthday) 41 yrs		10. IF UNDER 1 YEAR: Months 1 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Carlisle		14. MOTHER'S MAIDEN NAME Annie Berry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 526-34-1714	
17. INFORMANT Leon C. Merkel, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanomatosis 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 1-16-56 , 19__, to 7-20-57 , 19__, that I last saw the deceased alive on 7-12-57 , 19__, and that death occurred at 9 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 7-22-57			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23/57	
22c. NAME OF CEMETERY OR CREMATORY Jessop's		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE 7-22-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07217 CERTIFICATE OF DEATH

07199 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore (Essex) MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 360 Townsend Road.,				c. LENGTH OF STAY IN 1b Essex, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home 360 Townsend Road.,				d. STREET ADDRESS 360 Townsend Road.,			
3. NAME OF DECEASED (Type or print) First Evelyn Middle Martha Last Merling				4. DATE OF DEATH Month 7 Day 2 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/20	9. AGE (In years last birthday) 37 yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		
13. FATHER'S NAME Love			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT (Husband) Frank A.		Address 360 Townsend Road.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 12 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Feb. 13 , 19 52 , to July 2 , 19 57 , that I last saw the deceased alive on July 1 , 19 57 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7/5/57							
ACTUAL SIGNATURE Joseph Miceli		M.D. Joseph Miceli, M.D. 108 S. Taylor Ave., Essex 21, Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) _____ (State) _____ German Hill Road., Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith S. Connelly				ADDRESS 418 Eastern AVE. Essex, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 1957	
				24b. REGISTRAR'S SIGNATURE Edith S. Connelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1955

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07218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Washington & Penn. Avenues			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benjamin Middle Benson Last Merryman				4. DATE OF DEATH Month 7 / Day 16 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2, 1876		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Merryman				14. MOTHER'S MAIDEN NAME Catherine Cross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-18-8696		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 11200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 5 , 19 57 , to July 16 , 19 57 , that I last saw the deceased alive on 7/16 , 19 57 , and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED BRUNO RADAUSKAS M.D. SPRING GROVE STATE HOSPITAL 7/16/1957							
ACTUAL SIGNATURE Bruno Radauskas				PHYSICIAN'S NAME (Type) Bruno Radauskas Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ar. ...				ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE JUL 19 57	
				24b. REGISTRAR'S SIGNATURE Ar. ...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07201

07219

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Black Rock Road		d. STREET ADDRESS Black Rock Road	
3. NAME OF DECEASED (Type or print) John First E. Middle Merryman Last		4. DATE OF DEATH July Month 28 Day 1957 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Merryman		14. MOTHER'S MAIDEN NAME Rosella K. Armacost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 301-10-7521	
17. INFORMANT Blanche Martin Address Hampstead Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month July Day 27 Year 1957 Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 27, 1957 , to July 29, 1957 , that I last saw the deceased alive on July 27, 1957 , and that death occurred at 3: A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph E. Bush M.D.		ADDRESS (Street, city or town, state) Hampstead, Md	
PHYSICIAN'S NAME (Type) Joseph E. Bush M.D.		DATE SIGNED 7/29/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1/57	
22c. NAME OF CEMETERY OR CREMATORY Grace		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. D. Hipton ADDRESS Hampstead Md		24a. REC'D BY REGISTRAR 7-28-57	
		24b. REGISTRAR'S SIGNATURE Mary B. Elmer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 27 1957

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07134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5642 Carville Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE F LOUIS MILAN (also MILANO)		4. DATE OF DEATH Month July Day 26 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1893
9. AGE (In years last birthday) yrs. 63		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Route Owner		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dominick Milan		14. MOTHER'S MAIDEN NAME Victoria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-4231	
17. INFORMANT Katherine M. Milan		Address 5642 Carville Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month May Day 27 Year 1957 Hour 11 a. m. 00 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 27, 1957 to July 26, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Earl Pass M.D.		DATE SIGNED Aug 29 1957	
PHYSICIAN'S NAME (Type) J. EARL PASS, M.D.		ADDRESS (Street, city or town, state) 4001 W. Greenway Ave Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. **the funeral director, should be filed with**

VS A15 (4)
ISM 9/55

JUL 31 1957

RECEIVED
JUL 31 1957
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

072203

Reg. Dist. No.

1. PLACE OF DEATH (a) COUNTY <u>Catonsville 28 md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>		c. LENGTH OF STAY IN lb <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oak Hill Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hunt</u> Last <u>Miller</u> SR.		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1866</u>
9. AGE (In years last birthday) <u>90 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>90</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Miller</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Nina Brunner</u>		Address <u>MD 1305 Birch Ave. Arbutus</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures Compound Multiple Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Skull</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of throat (Cobalt therapy)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Rt Jumped off Roof</u>	
20c. TIME OF INJURY Hour <u>4:00</u> p. m. Month <u>7/31</u> Year <u>1957</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. (City or town) (County) (State) <u>Catonsville 28 md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. Mc Grath M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors</u>		24a. REC'D BY REGISTRAR <u>Aug 6</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

LEAU V. S.

1882

OFFICIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07221

CERTIFICATE OF DEATH

07204 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7806 Oak Ave.				d. STREET ADDRESS 7806 Oak Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Miller Last				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1864	
9. AGE (In years last birthday) 92 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown Braun				14. MOTHER'S MAIDEN NAME Henrietta M. Schmidt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Joseph P. Miller Address 2814 Linwood Ave. 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular peripheral disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 14, 1957 to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 6:20 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 6217 Hartford Rd				DATE SIGNED 7/17/57			
ACTUAL SIGNATURE E. J. Alessi				M.D. E. J. Alessi, M. D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 22 1957	
				24b. REGISTRAR'S SIGNATURE A. G. M. Bacon			

BUREAU V. S.


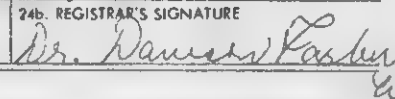
JUL 29 1957

RECEIVED

07222

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1929 Maisel Street			
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last MOORE				4. DATE OF DEATH Month July Day 8 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/94		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Greensburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.A.A.	
13. FATHER'S NAME Charles Moore				14. MOTHER'S MAIDEN NAME Lydia Lingie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec. Folder. Vet. Adm. Hosp., Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DUE TO						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bladder Calculus. Cystitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County) VA
21. I certify that VA attended the deceased from June 28, 19 57 , to July 8 , 19 57 , and that death occurred at 7:25 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE 				ADDRESS (Street, city or town, state) VAH, Fort Howard, Md.			
DATE SIGNED 7/8/57							
PHYSICIAN'S NAME (Type) GARFIELD D. KINGTON, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight				ADDRESS Wm Cook - Blight Funeral Home, St. Paul & Preston Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 7/12/57	
				24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 15 1917

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07206

33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN lb 10 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Academy Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle ST. CLAIR Last MOSS				4. DATE OF DEATH Month July Day 9 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Pvt. family		11. BIRTHPLACE (State or foreign country) Gwynbrook, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Branson				14. MOTHER'S MAIDEN NAME Nannie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Viola Eley, 502 Pleasant Hill Rd., Owings Mills, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary anemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Ca. of stomach (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 151X none none							
INTERVAL BETWEEN ONSET AND DEATH 3-4 mos. 1 yr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) (County) (State) none			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 7-11-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 13 July 57		22c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT		22d. LOCATION (City, town, or county) (State) OWINGS MILLS, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willard Funeral Home 1631 Druid Hill Ave.				24a. REC'D BY REGISTRAR 16 1957			
24b. REGISTRAR'S SIGNATURE Thos Eley							

MEDICAL CERTIFICATION

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 1 1957

BUREAU V. S.

TO DEPT
OF JUSTICE
FORWARD
TO FUNERAL

VS. A15ME/
5M 9/55

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any dis-
rification, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral
to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your
DIRECTOR: Page 3 should be used as a burial-transit permit. File number 1 and 2 with the

necessary, please e-
for. Page 4 should be
to burial exemption

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07207

Reg. Dist. No.

44

e7224

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Canillo MUSCELLO		4. DATE OF DEATH Month 7 Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-91
9. AGE (In years) 65 yrs.		IF UNDER 1 YEAR Months 9 Days 6	IF UNDER 24 HRS. Hours 6 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Driller		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	
11. BIRTHPLACE (State or foreign country) Torano Nuovo-Teramo-Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominic Muscello		14. MOTHER'S MAIDEN NAME Rosa Di Giantomaso	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-0133	
17. INFORMANT Mary Muscello (Wife)		Address 3156 Woodring Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fractured skull. Subluxation of right DUE TO ankle. Almost complete avulsion of glans penis. Conditions, if any, which gave rise to immediate cause (b) D.O.A. (c) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by an automobile on Shipyard Road, near Flange Mill	
20c. TIME OF INJURY Month, Day, Year 7-27-1957 Hour, o. m. 7:25 PM		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B.E. Shipyard		20f. (City or town) Sparrows Point (County) Balto (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin E. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30 1957	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Valle		24a. REC'D BY REGISTRAR JUL 29 1957	
		24b. REGISTRAR'S SIGNATURE Lawrence L. Farley	

MEDICAL CERTIFICATION

or removal.

5

RECEIVED

JUL 30 1957

BUREAU V. S.

07225

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8031 Highpoint Road</u>				d STREET ADDRESS <u>8031 Highpoint Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. Peter Paul Mutchok</u>				4. DATE OF DEATH <u>July 10th 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 27, 1917</u>	
9. AGE (In years last birthday) <u>39</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Mutchok</u>				14. MOTHER'S MAIDEN NAME <u>Mary (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Mrs. Mary Mutchok, 8031 Highpoint Road.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Essential Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Several years</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4444</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March, 1955</u> to <u>July, 1957</u> , that I last saw the deceased alive on <u>July 10, 1957</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>William A. Harris</u> M.D.				<u>8100 Hargord Road</u> <u>7/11/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. S. Elliott Harris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Hargord Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>7/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>W.A. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

JUL 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07226

CERTIFICATE OF DEATH

07299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6311 Mossway</u>				d. STREET ADDRESS <u>6311 Mossway</u>			
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Ross</u> Last <u>Myers Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1901</u>		9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ch. of board</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery Supplies</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J. Ross Myers</u>				14. MOTHER'S MAIDEN NAME <u>Emma Barnitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. J. Ross Myers</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162X METASTATIC CARCINOMA OF BRAIN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>IRONSTROGENIC CARCINOMA OF BRAIN</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>2</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>July 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Scott</u> M.D.				PHYSICIAN'S NAME (Type) <u>John M. Scott</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Tichner & Sons - Balt</u>				24a. REC'D BY REGISTRAR DATE <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 18 1957

BUREAU V. S.

07227

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57. Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Convalescent Home</u> <u>93 Smithwood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilhelmine L. Neuman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>George F. Neuman, 24 Sanford Ave, Catonsville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.2</u> DUE TO <u>Hemiplegic Right. Degenerative Heart Disease with Auricular Fibrillation.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>32. Confusions follow & scalp incident to fall after stroke</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21, 1957</u> to <u>July 21, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McCreath</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Ave. Catonsville 28 md</u> DATE SIGNED <u>7/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>AUG 24 '57</u> 24b. REGISTRAR'S SIGNATURE <u>W. E. McCreath</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 24 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

CERTIFICATE OF DEATH

072113/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1921 Gwynn Oak Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose A. Nolan		DATE OF DEATH Month July Day 20 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1898
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dennis Walsh		14. MOTHER'S MAIDEN NAME Ellen Byrne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO —	
17. INFORMANT Mr. Patrick J. Nolan - 1921 Gwynn Oak		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 month			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 57 , to 7/20 , 19 57 , that I last saw the deceased alive on 7/19 , 19 57 , and that death occurred at 6 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6411 Windsor Mill Rd. Md. DATE SIGNED 7/20/57			
ACTUAL SIGNATURE Milton Schlenker		PHYSICIAN'S NAME (Type) Milton Schlenker MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 23, 1957	22c. NAME OF CEMETERY OR CREMATORY New Cathara	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		24a. REC'D BY REGISTRAR 7/23/57	
ADDRESS 6411 Windsor Mill Rd.		24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin	

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Ellen B. Fane

Don't miss it

Mr. Gustav J. Nelson - 1251 Highland Ave.

BUREAU V. 8.

23 JUL 23 1957

RECEIVED

John Stanford - 1011 W. 12th St. N. W. Wash. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07212 38

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07229

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bendix Corp</i>				d. STREET ADDRESS <i>7551 Berkshire Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Le Roy Hall Nowell</i>				4. DATE OF DEATH Month Day Year <i>July 11th 19 57</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, -1913</i>		9. AGE (In years last birthday) <i>43</i> yrs.	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Nowell</i>				14. MOTHER'S MAIDEN NAME <i>Elsie M. Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-03-5683</i>		17. INFORMANT Address <i>Mrs. Mary E. Nowell, 7551 Berkshire Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4 1.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. [b] DUE TO [c]				INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>7/11/57</i>	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 16 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Mark L. Guss</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

U. S. 13 1-7

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07230

CERTIFICATE OF DEATH

07213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3601-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 316 N. Athol Ave. - Apt. B e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) IRENE First		Middle E.		Last OSBOURN		4. DATE OF DEATH July 3, Month Day Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1890		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Blackford Osbourn				14. MOTHER'S MAIDEN NAME Charlotte Kratz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. William E. Osbourn, Jr. - 3512 Essex Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple metastases from carcinoma of left breast DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 23, 19 56 to July 3, 19 57 , that I last saw the deceased alive on July 3, 19 57 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 7/5/57							
ACTUAL SIGNATURE George A. Knipp M.D.			PHYSICIAN'S NAME (Type) George A. Knipp, M. D. Baltimore 29, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickners & Sons - Baltimore ADDRESS				24a. REC'D BY REGISTRAR JUL 5 '57		24b. REGISTRAR'S SIGNATURE Paul...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD V. S.

RECEIVED

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED
JUL 18 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07215

07232

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 116 days			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d STREET ADDRESS 537 Moore Street			
3. NAME OF DECEASED (Type or print) First JAMES Middle L Last PARKER				4. DATE OF DEATH Month July Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 6, 1922	9. AGE (In years last birthday) yrs. 35	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13. FATHER'S NAME Richard Parker			14. MOTHER'S MAIDEN NAME Helen Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from March 29 , 19 57 , to July 23 , 19 57 , and that death occurred at 11:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND DATE SIGNED 7/24/57							
ACTUAL SIGNATURE Harold R. Johnson PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jul 29		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Adelphus Halstead Funeral Home, 918 Druid Hill Ave.				24a. REC'D BY REGISTRAR, DATE JUL 25 1957 24b. REGISTRAR'S SIGNATURE Dawson L. Parker			
Baltimore 1, Maryland							

RECEIVED

JUL 25 1957

BUREAU V. S.

07233

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN TB <u>2 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3626 Estler Place</u> d. STREET ADDRESS <u>Baltimore, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Gail</u> Middle <u>Fern</u> Last <u>Pasterfield</u>		4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>19 57</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/21/54</u>		9. AGE (In years last birthday) <u>3</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Leroy Pasterfield</u>								14. MOTHER'S MAIDEN NAME <u>Mary Altavater</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Parents and Rosewood records</u> Address <u> </u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inspiratory Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydrocephalus with complicating quadriplegia</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>July 6,</u> 19 <u>55,</u> to <u>July 23,</u> 19 <u>57,</u> that I last saw the deceased alive on <u>July 23, 1957,</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u> DATE SIGNED <u>7/24/57</u>																	
ACTUAL SIGNATURE <u>Harry G. Butler</u>				M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>				LOCATION (City, town, or county) (State) <u>Rosewood State Training School Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/24/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore St. Balto</u>								24a. REC'D BY REGISTRAR <u>7/24/57</u>				24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician and completely filled out by the funeral director. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 26 1957

RECEIVED

C7234

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TOWSON CONVAL. HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLEDA</u> <u>WELSH</u> <u>PEPPLER</u>				4. DATE OF DEATH Month Day Year <u>JULY</u> <u>14</u> <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 31, 1889</u>	
9. AGE (In years last birthday) yrs <u>67</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>6</u> <u>13</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>THOMAS WELSH</u>				14. MOTHER'S MAIDEN NAME <u>OLA PAINTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>214-22-5615</u>			
17. INFORMANT <u>EDGAR-A-PEPPLER</u>				Address <u>COCKEYSVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arterio-sclerotic vascular disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>? yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4/12/57</u> , 19____, to <u>7/14/57</u> , 19____, that I last saw the deceased alive on <u>7/14/57</u> , 19____, and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>7/15/57</u> DATE SIGNED <u>Edwin B. Jarrett</u> M.D. <u>11 East Chase St., Baltimore-2, Md.</u>							
ACTUAL SIGNATURE <u>Edwin B. Jarrett</u>				PHYSICIAN'S NAME (Type) <u>Edwin B. Jarrett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY-16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JESSOP M.E.</u>		22d. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. COOK-TOWSON, INC. TOWSON - MD.</u>				24a. REC'D BY REGISTRAR <u>JUL 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UL 1057

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 355 EUDOWOOD DRIVE		d. STREET ADDRESS 355 EUDOWOOD LANE	
3. NAME OF DARLENE M. PITTS (Type or print) First Middle Last		4. DATE OF DEATH JULY 21 1957 Month Day Year	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-57
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR 21 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH HUSEN		14. MOTHER'S MAIDEN NAME ANNIE D. PITTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT —		Address —	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 WKS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE William A. Pillsbury M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/21/57
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY Stephenson
22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Chas. E. Blatzman ADDRESS 1701 M. E. Culbertson		24a. REC'D BY REGISTRAR — DATE 25 1957
24b. REGISTRAR'S SIGNATURE Mabel Gray		

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records prior to burial, cremation or removal.

RECEIVED

JUL 25 1957

BUREAU V. 51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07219
Reg. Dist. No.

C7236

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yrlmth16dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 1 N. Meadow Rd. 165 Meadow Road	
3. NAME OF DECEASED (Type or print) First FLoyd Middle Louis Last Perstmann Sr.		4. DATE OF DEATH Month July Day 18 Year 19 57	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY railroad	11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Julius V. Perstmann	
14. MOTHER'S MAIDEN NAME Nettie May Meyers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOS ITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Asphyxia (c) Foreign body in bronchus (ingested food) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) strangled while eating dinner	
20c. TIME OF INJURY Month, Day, Year July 18 1957 Hour 12-15 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		DATE SIGNED July 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McBally - 10012 Hones Rd. B. Park Ave.		24a. REC'D BY REGISTRAR DATE 7-22-57	24b. REGISTRAR'S SIGNATURE DeW. Smith

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUL 22 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

CERTIFICATE OF DEATH

07240

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ebenezer Rd.</u>				e. STREET ADDRESS <u>Ebenezer Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Clinton A. Porter</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1877</u>	9. AGE (In years last birthday) <u>80</u> ym.	10. UNDER 1 YEAR <input type="checkbox"/> 1-24 HRS. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Porter</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Dorothy Porter</u> Address <u>Ebenezer Rd, Chase, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostate, c</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs. -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 25, 1957</u> , to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thos E. Gressner</u> M.D.				ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orem's Methodist</u>		22d. LOCATION (City, town, or county) <u>Balto., Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louisa Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>JUL 31 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

07238

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rheem Manufacturing Co.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 6937 Conley Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elwood Middle Price Last Price				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 29, 1916	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 18 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper		10b. KIND OF BUSINESS OR INDUSTRY Rheem Manufacturing	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME William Price				14. MOTHER'S MAIDEN NAME Elsie Collett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 189-05-1649		17. INFORMANT Mrs. Dorothy Price Address 6937 Conley Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO with Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 mrs. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from April 1957 to July 18, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED John E. Gorman							
ACTUAL SIGNATURE John E. Gorman M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.				24a. REC'D BY REGISTRAR JUL 23 1957			
24b. REGISTRAR'S SIGNATURE Lilly & Zeiler Inc.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 28 1911

RECEIVED

07222/44

07239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2535 Arunah Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. QUEEN				4. DATE OF DEATH Month Day Year July 3 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1923	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greaser		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Queen				14. MOTHER'S MAIDEN NAME Goldie Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 217-22-0538		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY						INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. Day. Year VA	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June 3, 1957 to July 3, 1957 . I live on _____ and the death occurred at 5:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 7/3/57							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home, 2001 Orleans, Balto. Md.			24a. REC'D BY REGISTRAR JUL 5 1957				
			24b. REGISTRAR'S SIGNATURE Dawson L. Farley				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 9 1961

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

CERTIFICATE OF DEATH

07223

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mths 3dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Waldorf, Maryland				d. STREET ADDRESS Waldorf, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Robert Last Rawlings				4. DATE OF DEATH Month July Day 5 Year 19 57			
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 7 Days 3 Hours 15 Min 57	IF UNDER 24 HRS Months 7 Days 3 Hours 15 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Benjamin Franklin			
14. MOTHER'S MAIDEN NAME ? DeVaughn				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene left foot DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
INTERVAL BETWEEN ONSET AND DEATH 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from April 24 , 19 57 , to July 5 , 19 57 , that I last saw the deceased alive on July 5 , 19 57 , and that death occurred at 12:10am , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsl				DATE SIGNED 7-5-57			
PHYSICIAN'S NAME (Type) Stella Wachsl, M. D.				ADDRESS (Street, city or town, state) CATONSVILLE 28, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Brookfield Methodist Naylor		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE JUL 9 '57		24b. REGISTRAR'S SIGNATURE W. H. Beach	

BUREAU V. S.

JUL 9 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(7241

CERTIFICATE OF DEATH

07224

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b 55 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2118 Lorraine Park Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle L. Last Reed				4. DATE OF DEATH Month July Day 10, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1881	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Samuel A. Reed				14. MOTHER'S MAIDEN NAME Sallie Younger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-01-1967A		17. INFORMANT Address Mrs. Eva L. Reed 2118 Lorraine Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-vascular Acc. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 6/20 , 19 57 , to 7/11 , 19 57 , that I last saw the deceased alive on 7/9 , 19 57 , and that death occurred at 10 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Winasos Mill Rd. DATE SIGNED 7/11/57 ACTUAL SIGNATURE Milton Schlenker M.D. PHYSICIAN'S NAME (Type) Milton Schlenker MD Baetz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-13-1957	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) Baltimore Md.				
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong 307 W. North Ave.			24a. REC'D BY REGISTRAR JUL 15 1957	24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 15 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07242

CERTIFICATE OF DEATH

07225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ston Ridge Nursing Home</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>	
3. NAME OF DECEASED (Type or print) <u>COYA ELIZABETH REYNOLDS</u>		4. DATE OF DEATH <u>July 6</u> 19 <u>57</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nathan Hemmiller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth A. Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. James Elia</u>		Address <u>5502 Pembroke Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular lesion Cerebral</u> DUE TO (c) <u>24 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis severe & deformed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> 19 <u>55</u> , to <u>July 6</u> 19 <u>57</u> , that I last saw the deceased alive on <u>July 6</u> 19 <u>57</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Katliff Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>4605 Edmondson Ave</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF KATLIFF JR.</u>		DATE SIGNED <u>7/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cypress Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Calverville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth H. Hight - Calverville, Md.</u>		24a. REC'D BY REGISTRAR <u>Jul 10 1957</u>	
ADDRESS <u>Calverville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Ketchum</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

UL 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN It 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 E. Overlea Ave.				d. STREET ADDRESS 14 E. Overlea Ave.			
3. NAME OF DECEASED (Type or print) First Gustave Middle H. Last Rippert				4. DATE OF DEATH Month July Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pay Master		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Rippert				14. MOTHER'S MAIDEN NAME Unknown Ficken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.H. # 1 212-09-8169		17. INFORMANT Mrs. Lois L. Rippert 14 E. Overlea Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) undet. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH approx 2 hrs.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-21-57			
EXAMINER'S NAME (Type) JOHN C. Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) New Orleans, La.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassohn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR JUL 23 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Rippert	

BUREAU V. S.

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Powers Avenue</u>				d. STREET ADDRESS <u>Powers Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ada Estel</u> <u>a</u> <u>Roberts</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>31</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1895</u>	9. AGE (In years last birthday) <u>62</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles E Francis</u>				14. MOTHER'S MAIDEN NAME <u>Many Ann Tombit</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give year or dates of service) <u>None</u>		17. INFORMANT Address <u>Lawrence Roberts-Cockeysville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO 4. <u>Anteriosclerotic cardi-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Anteriosclerotic cardi-vascular disease</u> (c) <u>dis ease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>10 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>42 d. i.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>July</u> , <u>1957</u> , that I last saw the deceased alive on <u>July 27</u> , <u>1957</u> , and that death occurred at <u>8 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Elizabeth B. Sherrill</u> M.D. <u>Cockeysville, Maryland</u> <u>7/21/57</u> ACTUAL SIGNATURE <u>Elizabeth B. Sherrill</u> <u>Cockeysville, Md.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Providence Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Providence, Balto. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u>				ADDRESS <u>Towson, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 2 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 2

RECEIVED

07245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN lb <u>1mth 28dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>2842 Clifton Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Christina</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Frederick W. Lammers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Christina Hoffmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 24</u> , 19 <u>57</u> , to <u>July 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>57</u> , and that death occurred at <u>3:30 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>7-22-57</u>							
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Howard Strong</u> ADDRESS <u>307 W. 6th Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 24 57</u>			
				REGISTRAR'S SIGNATURE <u>W. F. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07246

CERTIFICATE OF DEATH

0722944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 44 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2618 Shirley Avenue			
3. NAME OF DECEASED (Type or print) First ISADORE Middle JAKE (Also: ROBINSON)				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman- Unemployed				10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Winston Salem, N. Carolina	
13. FATHER'S NAME Eli Robinson				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). ADENOCARCINOMA OF BRONCHUS OF UPPER LOBE OF RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month VA Day 19 Hour a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 3, 1957 to July 17, 1957 . XXXXXX and that death occurred at 10:28 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Irving Freeman M.D.				VA HOSPITAL, FORT HOWARD, MARYLAND 7/17/57			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Place, Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Lark	

BUREAU V. S.

100-100000

07247

CERTIFICATE OF DEATH

0723038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN 1b 6 years		d. STREET ADDRESS 1001 West Joppa Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 West Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SISTER MARY RODRIGUEZ (Catherine Gillespie)		4. DATE OF DEATH Month July Day 15 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1876
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months 10 Days 4 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Ballinascreen, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Gillespie		14. MOTHER'S MAIDEN NAME Eliza Barnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Road, Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 442x DUE TO Hypertensive Cardio-Renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 7, 1947 to July 15, 1957 , that I last saw the deceased alive on July 10, 1957 , and that death occurred at 4:00 PM , from the cause and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Road DATE SIGNED 7/16/57	
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		7501 York Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery	22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		24. REGISTAR'S SIGNATURE Michael G. Gayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3, 4, and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 18 1957
BUREAU V. L.

C7248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) ARMACOST NURSING HOME REGESTER AVE		d. STREET ADDRESS 4305 MARBLE HALL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRY A ROHMER		4. DATE OF DEATH JULY 21, 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1900	
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALEMAN		10b. KIND OF BUSINESS OR INDUSTRY LIQUOR	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER A ROHMER		14. MOTHER'S MAIDEN NAME BABETTE LEDERER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. DOROTHY E ROHMER		Address 4305 Marble Hall Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-20-50 to JULY 21, 1957 that I last saw the deceased alive on JULY 20, 1957 and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1532 HAYENWOOD RD. BALTO MD. DATE SIGNED ARTHUR KARFGIN			
22. I certify that I attended the deceased from 5-20-50 to JULY 21, 1957 that I last saw the deceased alive on JULY 20, 1957 and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1532 HAYENWOOD RD. BALTO MD. DATE SIGNED ARTHUR KARFGIN			
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Inc. 127 St. Paul Street ADDRESS 127 St. Paul Street			
24a. REC'D BY REGISTRAR DATE JUL 23 1957 24b. REGISTRAR'S SIGNATURE Mabel Green			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

BUREAU V. 51

1957

RECEIVED

07249

CERTIFICATE OF DEATH

Reg. Dist. No.

07332

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X3 Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7834 Wendover Ave</i>		d. STREET ADDRESS <i>1 7834 Wendover Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Alessandro</i> Middle <i>Rosellini</i> Last <i>Rosellini</i>		4. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 13, 1889</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i> ✓	
13. FATHER'S NAME <i>Niccola Rosellini</i>		14. MOTHER'S MAIDEN NAME <i>Zelinda Gabani</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-07-7876</i>	
17. INFORMANT <i>Mrs. Josephine Rosellini</i>		Address <i>7834 Wendover Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Stomach with</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized metastasis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>19 mos.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 15, 1956</i> to <i>July 29, 1957</i> , that I last saw the deceased alive on <i>7/23</i> , 1957, and that death occurred at <i>6:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Nathan Janney</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>7101 Harford Rd. 7/30/57</i>	
PHYSICIAN'S NAME (Type) <i>Nathan Janney</i>		<i>Baltimore 14, Ind.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug. 1, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	
24a. REC'D BY REGISTRAR <i>11/1</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

BUREAU V. A.

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07250

CERTIFICATE OF DEATH

07233

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb Nursing Home - 4105 Essex Rd.				d. STREET ADDRESS 732 Milford Mill Rd.			
3. NAME OF DECEASED (Type or print) First CATHERINE Middle AUGUSTA Last ROWLES				4. DATE OF DEATH Month July Day 20 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Julius F. Scriba				14. MOTHER'S MAIDEN NAME Mary R. Douglass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO no		17. INFORMANT Mr. Charles D. Rowles - 732 Milford Mill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis							
332 X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Generalized arteriosclerosis							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Diabetes Mellitus, abscess buttock							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 9, 1949 , to July 18, 1957 , that I last saw the deceased alive on 18 July, 19 57 , and that death occurred at 7:15 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1632 Reis Rd., Pikesville 8, Md.							
22. DATE SIGNED 22 July							
ACTUAL SIGNATURE Charles H. Williams July 20, 1957							
PHYSICIAN'S NAME (Type) Charles H. Williams, M.D., 1632 Reisterstown Rd., 8, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
no		7/22/57		Loudon Park Cem.		Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickenery Sons - Balt.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7/23/57	
						24b. REGISTRAR'S SIGNATURE Dr. Wm. J. Martin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical examiner, Dr. DD Caples advised Dr. Williams to sign.
Patient was seen by Dr. Paul Royse on July 20, day of death.

BUREAU V. S.

JUL 24 1957

RECEIVED

07251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARCHIE Middle D. Last RULE				4. DATE OF DEATH Month July Day 14 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/97	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Publishing House	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William P. Rule		14. MOTHER'S MAIDEN NAME Martha Fielder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 237-14-5270		17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH FEW MINUTES 3 YEARS				PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from June 14 19 57 , to July 14 19 57 , and that death occurred at 10:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. Veterans Administration Hospital 7/15/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief Medical Fort Howard, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-15-57		22c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Airy, N. Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS Wm. Cook-Blight, Inc. 6009 Harford Rd., Baltimore 11				24a. REC'D BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be filed with page 3. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07252

CERTIFICATE OF DEATH

07235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Forge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Forge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 Branden Road		d. STREET ADDRESS 107 Branden Road	
3. NAME OF DECEASED (Type or print) Margaret Miller Samuels		4. DATE OF DEATH Month July Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1913
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME H. Sinclair Miller		14. MOTHER'S MAIDEN NAME Anne Ruwart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John B. Miller		Address 7222 Linark Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis from DUE TO (c) Carcinoma of colon			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1947 to July 5, 1957 , that I last saw the deceased alive on 7-5-1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas Edgell Russell, M.D.		ADDRESS (Street, city or town, state) 3901 N. Charles St.	
PHYSICIAN'S NAME (Type) Thomas Edgell Russell, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 8, 1957	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Pl.	
24a. REC'D BY REGISTRAR JUL 10 1957		24b. REGISTRAR'S SIGNATURE Mark Grey	

RECEIVED

JUL 10 1957

BUREAU V. S.

07130

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7147 Holabird Avenue				d. STREET ADDRESS 7147 Holabird Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Percy Last Samuels		4. DATE OF DEATH Month July Day 17 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1898	9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Middletown, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Samuels				14. MOTHER'S MAIDEN NAME Anne Leichen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 232-20-2214		17. INFORMANT William H. Samuels, 6102 Fortview Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1957, to 17 July , 1957, that I last saw the deceased alive on 13 July , 1957, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2908 DUNRAN RD DATE SIGNED 7-19-57							
ACTUAL SIGNATURE B.W. Sollod		M.D. 2908 DUNRAN RD					
PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.		Dundalk - 22 - Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 22 1957		24b. REGISTRAR'S SIGNATURE Am. Kelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be moved to the back of the certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 22 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

07253

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7801 Oak Avenue</u>				d. STREET ADDRESS <u>7801 Oak Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Eva Estelle Schafer</u>				4. DATE OF DEATH Month Day Year <u>July 7th 1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>triez Instruments</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Pool</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Mr. Harry J. Schafer, Sr. 7801 Oak Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of St. ovary</u> <u>175X</u> DUE TO <u>with metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>July 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>57</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8100 Harford Road #14</u>				DATE SIGNED <u>7/8/57</u>			
ACTUAL SIGNATURE <u>Nichols Harris</u> M.D.							
PHYSICIAN'S NAME (Type) <u>S. Elliott Harris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>Jul 12 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Thompson</u>			

RECEIVED

JUL 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07131

CERTIFICATE OF DEATH

0723841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 S. Dundalk Ave.		d. STREET ADDRESS 60 S. Dundalk Ave.	
3. NAME OF DECEASED (Type or print) First ROSINE Middle SCHLAILE Last		4. DATE OF DEATH Month July Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany
13. FATHER'S NAME Ludwig Friz		14. MOTHER'S MAIDEN NAME Fredericka ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO	17. INFORMANT Address Mrs. Bertha Golly 60 S. Dundalk Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 to 16 July , 19 57 , that I last saw the deceased alive on 14 July , 19 57 , and that death occurred at 11 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. W. SOLLARD		ADDRESS (Street, city or town, state) 2900 Dunstan Rd	
PHYSICIAN'S NAME (Type) B. W. SOLLARD, M.D.		DATE SIGNED 7-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE 19 1957	
		24b. REGISTRAR'S SIGNATURE Tom Kelly	

RECEIVED

JUL 22 1957

BUREAU V. B.

07254 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. NAME OF DECEASED (Type or Print) HOWARD SCHEFF			2. DATE OF DEATH 7-10-57		
3. PLACE OF DEATH: Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 705 Stoneleigh RD, Baltimore 12			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) STONELEIGH-Baltimore 12		
D. STREET ADDRESS (If rural, give location) 705 Stoneleigh RD.			E. LENGTH OF STAY IN BALTIMORE life		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH July 8, 1897.	9. AGE (In year, last birthday) 60	10. Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Building Contractor		
11. BIRTHPLACE (State or foreign country) Baltimore City			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Scheff			14. MOTHER'S MAIDEN NAME Barbara Kahl		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 1216-01-3432		
17. INFORMANT Josephine Scheff, same			ADDRESS		
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis, recurrent			INTERVAL BETWEEN ONSET AND DEATH few minutes		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Anteriosclerotic cardiovascular disease			DATE Sept 1938		
20. TIME (Month) (Day), (Year) (Hour) OF INJURY July 1957			21. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from July 1957 , that (I) (we) last saw the deceased alive on July 8, 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.			23. DATE SIGNED 7-10-57		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-13-57		
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem			24D. LOCATION (City, town, or county) (State) Baltimore MD		
25. FUNERAL DIRECTOR Leonard J. Kuck			ADDRESS 5305 Harbor		

REGISTRAR

VS:

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WAXEN BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information supplied. Physicians; please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER THE DATE OF DEATH.

RECEIVED

UL 16 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07255 **CERTIFICATE OF DEATH**

Reg. Dist. No. 40

07240

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CONVENTON</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CONVENTON</u>		TOWN <u>CONVENTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AFFELD AVE</u>				STREET ADDRESS (If rural give location) <u>AFFELD AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>Lewis</u> (First) <u>Schultz</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ANTONE SCHULTZ</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-0504</u>		17. INFORMANT & ADDRESS <u>HARRY SCHULTZ 3008 ROYSTON AVE</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4. IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Congestive Heart Failure</u>			
19a. DATE OF OPERATION <u>4-34-1</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 23, 1957</u> to <u>July 25, 1957</u>, that I last saw the deceased alive on <u>July 23, 1957</u>, and that death occurred at <u>12:40</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William W. Tyson</u>				ADDRESS (Street, city, town, state) <u>Kingsville Md.</u>		DATE SIGNED <u>7-25-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-27-57</u>		NAME OF CEMETERY OR CREMATORY <u>FORK METHODIST CHURCH</u>		LOCATION (City, town, or county) (State) <u>MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Walter H. Tyson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook-Blight, Jr.</u>		ADDRESS <u>6009 Hanford Rd.</u>	
DATE <u>7/29/57</u>							

BUREAU V. S.

JUL 26 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07243
28

Reg. Dist. No.

07256

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>				d. STREET ADDRESS <u>240 Rodgers Forge Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>240 Rodgers Forge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>JOSEPH</u> Last <u>SHAMBERGER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 20, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing Business</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u> </u>							
13. FATHER'S NAME <u>Daniel Shamberger</u>				14. MOTHER'S MAIDEN NAME <u>Martha J.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mr. C. Edwin Fitzell - 3342 Gilman Terrace</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>14 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Baltimore</u>				24a. REG'D BY REGISTRAR <u> </u>			
24b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>JUL 5 1957</u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use.

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07243

07257

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>29yr5mth14dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. STREET ADDRESS <u>Baltimore City Hospital</u>	
3. NAME OF DECEASED (Type or print) <u>Mollie Sheckells</u>		4. DATE OF DEATH <u>July 23 19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles R. Sheckells</u>		14. MOTHER'S MAIDEN NAME <u>Jane Minnifree</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture of skull</u>			
900.7 DUE TO (b) <u>due to a fall</u>			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. was pushed by another patient causing her to fall down steps with resulting injury of head.</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>6:20 AM 7-23-57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>		20f. (City or town) (County) (State) <u>Catonsville 28, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SPRING GROVE STATE HOSP.</u>		22d. LOCATION (City, town, or county) (State) <u>Catonsville 28, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SPRING GROVE STATE HOSPITAL</u>		24a. REC'D BY REGISTRAR <u>AUG 6 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>	

U. S. A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07258

CERTIFICATE OF DEATH

Iter 2 File 6718 8-1-51 et

07244

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>76 Fulton Avenue</u>		STREET ADDRESS <u>11411 Woodlawn Pl.</u>	
3. NAME OF DECEASED (Type or Print) <u>Solomon</u> (First) <u>Specter</u> (Middle) <u>Specter</u> (Last)		4. DATE OF DEATH <u>July 25</u> 19 <u>57</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salismon</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mfn.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT Country? <u>USA</u>	
13. FATHER'S NAME <u>late Samuel Specter</u>		14. MOTHER'S MAIDEN NAME <u>Lena Stetsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>11411 Woodlawn Pl.</u>	
17. INFORMANT AND ADDRESS <u>William Leppel - 3805 Hilton Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)...

(a)...

Carcinoma of Large Bowel

INTERVAL BETWEEN ONSET AND DEATH

2nd

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)...

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

June 14 57

19b. MAJOR FINDINGS OF OPERATION

Carcinoma bowel with metastases

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m. While at Work ☐ Not While At work ☐

INJURY OCCURRED

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1957, to July 15, 1957, that I last saw the deceased

alive on July 15, 1957, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

July 26 57

NAME OF CEMETERY OR CREMATORY

22th Chapel

LOCATION (City, town, or county)

Woodlawn, Md

(State)

DATE REC'D BY LOCAL REG

7/26/57

REGISTRAR'S SIGNATURE

W. H. H. H. H.

24. FUNERAL DIRECTOR

Sal Herman

ADDRESS

1124-26 W. North Ave

58

one

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 09 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07245

07259

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULLERTON</u> c. LENGTH OF STAY IN lb <u>PARKVILLE X2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8506 OAKLEIGH RD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE X2</u> d. STREET ADDRESS <u>8506 OAKLEIGH RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>A</u> Last <u>SHOOK</u> 4. DATE OF DEATH Month <u>7</u> Day <u>-27</u> Year <u>1957</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB 27 1931</u> 9. AGE (In years last birthday) <u>26</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINEMAN</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT H. SHOOK</u> 14. MOTHER'S MAIDEN NAME <u>VELMA CLEAVER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>MRS EUTHEN SHOOK 8506 OAKLEIGH</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE GUNSHOT WOUNDS OF</u> <u>981X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HEAD</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SILVER SPRING ROAD</u>		20c. TIME OF INJURY Month, Day, Year <u>9 15</u> Hour a. m. <u>7-27</u> 19 <u>57</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CAR- STREET</u> 20f. (City or town) <u>BALTIMORE</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R S Fisher</u> EXAMINER'S NAME (Type) <u>R S. FISHER</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-28-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>JULY 30 1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>DARKWOOD</u> 22d. LOCATION (City, town, or county) <u>PARKVILLE MD</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u> ADDRESS <u>4216 BELAIR</u> 24a. REC'D BY REGISTRAR <u>JUL 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. R. L. Reardon</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 30 1957

BUREAU V. 3

C7132 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY

BALTO

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN

BALTO - 22

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

BALTO

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

BALTO 22 - MD

STREET ADDRESS
(If rural give location)

2110 OAKLAND AVE Balto

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

FRANK J. SLOWIK Sr.

4. DATE

(Month)

(Day)

(Year)

OF
DEATH:

July 10

1957

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED.

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MALE WHITE

MARRIED Jan 30 1887

70 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired)10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

RETIRED PUMPING ST. BALTO. CITY

BALTO MD.

BALTO MD.

U.S.A

13. FATHER'S NAME:

MICHAEL SLOWIK

14. MOTHER'S MAIDEN NAME:

JOSEPHINE STREGOLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

BERTHA A. SLOWIK 2110 OAKLAND AVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42311
Immediate cause

(a) Cerebro Vascular accident

Interval Between
Onset and Death

Sudden

Antecedent causes (s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

DUE TO

(b) Arteriosclerotic Cardio Vascular disease 5 yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Jan 1, 1957, to July 10, 1957, that I last saw the deceased

alive on July 10, 1957, and that death occurred at 8 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BURIAL

July 18 1957

ST. STANISLAUS CEM.

DONDAN AVE

7/12/57

Wm. M. Kelly, Jr.

Marie Jankowski

1000 S. Kenwood Ave

Balto. 24 - Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 15 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07260

CERTIFICATE OF DEATH

07247

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebhrille</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebhrille</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3110 Rolling Road</u>				d. STREET ADDRESS <u>3110 Rolling Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>G</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 23, 1879</u>	
9. AGE (In years, last birthday) <u>77</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William C. Ness</u>			
14. MOTHER'S MAIDEN NAME <u>Lucy Gibson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Mr. John C. Smith - Dorsey, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dehydration - delirium</u> DUE TO <u>malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>July 15</u> , 19 <u>57</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>57</u> , and that death occurred at <u>3:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Carroll</u>				ADDRESS (Street, city or town, state) <u>—</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stensbury</u>				ADDRESS <u>6411 Windsor M. Rd.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>				24c. DATE <u>22 1957</u>		24d. REGISTRAR'S SIGNATURE <u>—</u>	

cc.

and

Ex 110

Heppell

Heppell

210 Rolling Road

210 Rolling Road

Smith July 12

Ide

July 22

female white

A. Z. H.

Gen.

Home

Scientific

each of these

William C. West

Mr. John Smith - Dec 22, 1917

— —

BUREAU V. S.

11 22 1917

RECEIVED

W. H. Lawrence

Printed at the Government Printing Office
Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07261

07248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) MARIE H. SMITH			2. DATE OF DEATH JULY 15, 1957		
3. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City		
B. FULL NAME OF (If not in hospital or institution, give street address or location) RIDGEWAY MANOR FOR AGED.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City.		
5743 Edmondson Ave. Balto. (28) Md.			D. STREET ADDRESS (If rural, give location) 707 North Port St. (5).		
c. Length of stay in Baltimore LIFE					
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, W. DOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 29, 1898	9. AGE (In years last birthday) 59	10. Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME Herman Schroeder			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO None		
17. INFORMANT Harold D. Smith			ADDRESS 7603 Maple Road Dundalk 22, Md.		
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage			CAUSE OF DEATH Cerebral Hemorrhage		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arterio Sclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 5 y.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OF PART 1			19A. DATE OF OPERATION		
21D TIME (Month) (Day) (Year) (Hour)			21E INJURY OCCURRED		
OF INJURY			21F HOW DID INJURY OCCUR?		
22 I certify that (I) (this hospital) attended the deceased from April 12, 1957 to July 15, 1957 , that (I) (we) last saw the deceased alive on July 15, 1957 , and that death occurred at 12:55 A.M. , from the causes and of the date stated above.			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
23A. SIGNATURE Wm. R. Meyer			23B ADDRESS 156 N. Meleton Ave		
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			23C. DATE SIGNED July 15, 1957		
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/18/57		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
24D. LOCATION (City, town, or county) BALTO., MD.		25. FUNERAL DIRECTOR N. Hartley Miller			
DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1957		ADDRESS 2334 Jefferson St.			

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and let THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

BUREAU W. S.

07262

CERTIFICATE OF DEATH

07249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IB 20yr6mth4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 824 Park Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Naomi Middle Todd Last Smith		4. DATE OF DEATH Month July Day 24 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR: Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathan J. Todd		14. MOTHER'S MAIDEN NAME Mary Bozman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22 , 19 57 , to July 24 , 19 57 , that I last saw the deceased alive on July 24 , 19 57 , and that death occurred at 4:25 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Stella Wachslar M.D.		SPRING GROVE STATE HOSPITAL 7-24-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	July 27, 1957	Cape Charles Cem.	Cape Charles Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton, Glen Burnie		24a. REC'D BY REGISTRAR DA 7-29-57	24b. REGISTRAR'S SIGNATURE Richard

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 20 1957

RECEIVED

07263

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD VA.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gwyn Oak.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOPEWELL VA.</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>				d. STREET ADDRESS <u>709 E. POYTHRESS ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AUGSBURG HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SARAH ANN SMITH.</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1884</u>	9. AGE (In years last birthday) <u>73</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD. PA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHAS MCKENNA.</u>				14. MOTHER'S MAIDEN NAME <u>KNEPP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Records AUGSBURG HOME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 3 -</u> , 19 <u>55</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 2 -</u> , 19 <u>57</u> , and that death occurred at <u>10:27 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul L. Chamberlain</u>				ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Baltimore Md.</u>			
PHYSICIAN'S NAME (Type) <u>Paul L. Chamberlain</u>				DATE SIGNED <u>4-6-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S VIOLETTVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul L. Chamberlain</u>				ADDRESS <u>6067 Hayford Rd</u>		24a. REC'D BY REGISTRAR <u>Dr. J. M. Masterson</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. Masterson</u>		DATE <u>JUL 9 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 9 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07251

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 18 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5106 Kenwood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ELLIS Middle O. Last SPENCER				4. DATE OF DEATH Month July Day 9 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mutual Clerk				10b. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) New Castle, Delaware	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William C. Spencer				14. MOTHER'S MAIDEN NAME Katherine Fluhardy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service Yes WW I				16. SOCIAL SECURITY NO 212-18-0392		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED PERITONITIS DUE TO PERFORATED GASTRIC ULCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Coronary arteriosclerosis. 2. Old myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from June 21, 19 57 , to July 9, 19 57 and that death occurred at 9:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 7/10/57							
ACTUAL SIGNATURE Chien Wei Ian M.D. VAH, FORT HOWARD, MARYLAND							
PHYSICIAN'S NAME (Type) CHIEN WEI IAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.				ADDRESS 2435 E. Oliver St., Balto, Md.		24a. REC'D BY REGISTRAR JUL 15 1957	
24b. REGISTRAR'S SIGNATURE Lawson L. Farley							

BUREAU V. S.

JUL 10 1917

RECEIVED

07265

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bella Nova</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto MD</u>			
c. LENGTH OF STAY in 1b <u>10 yrs</u>				3301-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesbury Home</u>				d. STREET ADDRESS <u>721 Sudharst St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary E.</u> Middle <u>Spillman</u> Last <u>Spillman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 16, 1870</u>	
AGE (In years, last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Balto Geo.</u>				12. CITIZEN OF WHAT COUNTRY? <u></u>			
13. FATHER'S NAME <u>John Zaiser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Rivard Home</u> Address <u>6811 Campfield</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (Recurrent)</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>							
b) <u>Arterio Sclerotic Heart Disease</u> <u>5 yrs</u>							
c) <u>Generalized Arterio Sclerosis</u> <u>4 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 1 - 1953</u> , to <u>July 29 - 1957</u> , that I last saw the deceased alive on <u>July 25 - 1957</u> , and that death occurred at <u>5:58 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>408 Liberty St Balto</u>				DATE SIGNED <u>7-19-57</u>			
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u> M.D. <u>408 Liberty St Balto</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 1, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellvue Cem</u>		22d. LOCATION (City, town or county) (State) <u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl G. Neumann</u> ADDRESS <u>6067 Hanford Rd</u>				24a. REC'D BY REGISTRAR <u>AUG 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. S. Master</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 5 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07266

CERTIFICATE OF DEATH

07253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 12yrl0mth24dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 724 S. Ann Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Stanislava Last Stanislava		4. DATE OF DEATH Month July Day 5 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1882
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY Parochial school	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Jacob Skrzyniecki		14. MOTHER'S MAIDEN NAME Frances Golembiewska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO (b) Myocardial degeneration + failure DUE TO (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rt breast		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26, 1956 to July 5, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred at 5:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gertrude J. Fleischmann M.D. SPRING GROVE STATE HOSPITAL 7.5.57			
ACTUAL SIGNATURE Gertrude J. Fleischmann		PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-8-57	
22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		22d. LOCATION (City, town, or county) (State) 1300 DUNDALK AVE	
23. FUNERAL DIRECTOR'S SIGNATURE George G. Weber 703 S. Ann St		24a. REC'D BY REGISTRAR DATE 9 9 57	
24b. REGISTRAR'S SIGNATURE Deborah			

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07267

CERTIFICATE OF DEATH

Reg. Dist. No.

07254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 1yrlmthl1dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 22 Sanders Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Edith Last Sterner				4. DATE OF DEATH Month July Day 5 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1899	
9. AGE (In years last birthday) 57 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Frederick List				14. MOTHER'S MAIDEN NAME Jinnie Gerlach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary occlusion DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 15 , 19 57 , to July 5 , 19 57 , that I last saw the deceased alive on July 5 , 19 57 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 7-5-57							
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				ADDRESS Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tichner				ADDRESS 400 North 4th Ave		24a. REGD BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

S. A. O. V. S.

1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07268

CERTIFICATE OF DEATH

07255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Masonic Home		d. STREET ADDRESS 2915 KESWICK ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH ELLSWORTH STONE		4. DATE OF DEATH Month Day Year JULY 20 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 yrs.
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES E. BURRIER		14. MOTHER'S MAIDEN NAME ANNA M. McCULLOUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-03-47698	
17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation due to 47 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiac DUE TO Vascular Disease (c)			INTERVAL BETWEEN ONSET AND DEATH over 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5/27 , 19 57 , to 7/19 , 19 57 , that I last saw the deceased alive on 7/19/57 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED			
ACTUAL SIGNATURE Walter T. Kuo		M.D. Cockeysville, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7-23-57	Druid Ridge	BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc		ADDRESS 12175 PAUL ST.	
24a. REC'D BY REGISTRAR DATE 8-4-57		24b. REGISTRAR'S SIGNATURE Paul	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

RECEIVED

JUL 04 1957

BUREAU V. S.

07269

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6708 Beech Ave.				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Franz Middle L. Last Struhs				4. DATE OF DEATH Month July Day 28 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1880	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min 77		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith-Retired				10b. KIND OF BUSINESS OR INDUSTRY Silversmith			
13. FATHER'S NAME John Struhs				14. MOTHER'S MAIDEN NAME Wilhelmina Wallring			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-2912		17. INFORMANT Address Mrs. Catherine Struhs 6708 Beech Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure 177X DUE TO metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO prostatic cancer (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 16, 1916 to July 28, 1917 , that I last saw the deceased alive on July 28, 1917 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. D. RIGLER				DATE SIGNED 1 W OVERLEA AVE			
PHYSICIAN'S NAME (Type) J. D. RIGLER				ADDRESS (Street, city or town, state) BALTO 6. Md 7-30-17			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cassidy Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR JUL 31 1957	
24b. REGISTRAR'S SIGNATURE Mal. L. Reynolds							

MEDICAL EXAMINATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 31 1957

RECEIVED

07270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO, 28		c. LENGTH OF STAY IN 1b 19yr7mthldy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE ST. HOSP.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 Essex	
3. NAME OF DECEASED (Type or print) First GLADYS Middle STUARTZ Last STUARTZ		4. DATE OF DEATH Month 7 Day 7 Year 1957	
5. SEX FEM	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-24-1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS L. NANCE		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BUY STURTZ HUSBAND		Address UNKNOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Arteriosclerotic coronary occluding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic + hypertensive cardiovascular disease DUE TO Arteriosclerotic + hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-7-57 , 19 57 , to 7-7- , 19 57 , that I last saw the deceased alive on 7-7- , 19 57 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		M.D. SPRING GROVE STATE HOSPITAL 7-9-57	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland	
22a. BURIAL-CREATION: <input checked="" type="checkbox"/> REMOVAL (Specify)	22b. DATE THEREOF 7-9-57	22c. NAME OF CEMETERY OR CREMATORY Cris. of Med. School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE JUL 10 '57	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 11 1957

BUREAU V. S.

07271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacoast Nursing Home				d. STREET ADDRESS 1504 Marble Hall Rd.			
3. NAME OF DECEASED (Type or print) First MAMIE Middle H. Last SWEARER				4. DATE OF DEATH Month July Day 14 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 30, 1877	
9. AGE (In years lost birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer (rtd)		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Swearer				14. MOTHER'S MAIDEN NAME Cornelia Owen Tomlinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Raymond R. Rever Address Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7/1/57 2yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 47X Worker Annapolis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1950 , 19____, to 7/14 , 19____, that I last saw the deceased alive on 7/13/57 , 19____, and that death occurred at 9:24 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE WATER E. KARFGIN M.D.				ADDRESS (Street, city or town, state) 41331 Harbor Rd DATE SIGNED 7/16/57			
PHYSICIAN'S NAME (Type) WATER E. KARFGIN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Balto.				24a. REC'D BY REGISTRAR JUL 18 1957		24b. REGISTRAR'S SIGNATURE Mark Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUL 18 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07259

C7135

CERTIFICATE OF DEATH

Reg. Dist. No.

4v

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>48 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Avenue</u>				d. STREET ADDRESS <u>1 Ridge Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOSEPHINE</u> First Middle Last				4. DATE OF DEATH <u>July 5 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12 - 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>STRUNG</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>420.1</u>			
17. INFORMANT <u>Julius Funder 423 Ridge Ave.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary - probably, subacute</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension - essential</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Stroke</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 or 6 weeks</u> <u>+ years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1 Overweight</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>57</u> , to <u>July 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>57</u> , and that death occurred at <u>AP</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frederic V. Beiler</u>				ADDRESS (Street, city or town, state) <u>M.D. 1014 Francis Ave - Balt 27 Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>FREDERIC V. BEILER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>July 9-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Blvd. Md.</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederic V. Beiler</u>				ADDRESS <u>1014 Francis Ave - Balt 27 Md.</u>			
24a. REC'D BY REGISTRAR <u>Dr. Geo M. Kuffner</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kuffner</u>			
DATE <u>JUL 9 1957</u>							

RECEIVED

JUL 9 1957

BUREAU V. S.

07272

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 33 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			
d. STREET ADDRESS 1041 West Lanvale Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SQUIRE Middle M. Last TAYLOR				4. DATE OF DEATH July 30 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1887	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	
10b. KIND OF BUSINESS OR INDUSTRY Self employed		11 BIRTHPLACE (State or foreign country) Rocky Mount, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Wesley Taylor				14. MOTHER'S MAIDEN NAME Mary S. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 219-16-7891		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 27 19 57 , to July 30 19 57 , and that death occurred at 8:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 7/30/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave. Baltimore 1, Maryland				24a. REC'D BY REGISTRAR DATE Aug 2-57		24b. REGISTRAR'S SIGNATURE Dawson L. Parker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 5 1

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07273

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>2mths 10dys</u>		d. STREET ADDRESS <u>909 Elm Ridge Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENT OF A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Emilia</u> Last <u>Thom</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1874</u>
9. AGE (in years, not birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>8</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> ✓	
13. FATHER'S NAME <u>August Thom</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Mielke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> <u>903.7</u> DUE TO (b) <u>cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>fracture left femur</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4</u> <u>accident</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>While walking on ward, pt. fell to floor, sustaining fractured left femur</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10:45</u> <u>7-9</u> <u>19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>	20f. (City or town) (County) (State) <u>Catonsville 28, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>George M. Kieffer</u>		DATE SIGNED <u>July 28 57</u>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Jones</u>		24a. REC'D BY REGISTRAR <u>4107 Lake</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

07274

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers, Rural</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beckleysville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>M.</u> Last <u>Tracey</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>Dec. 4, 1893</u> 63 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Irvin McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>183-188-13A</u>	
17. INFORMANT <u>James W. Tracey, Millers Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4" DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ch. Valvula Cardiac Disease</u> DUE TO (c) <u>Arterio</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COX</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>11</u> p. m. Month <u>May</u> Day <u>19</u> Year <u>1957</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat. while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>New Freedom</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19, 1957</u> to <u>July 18, 1957</u> that I last saw the deceased alive on <u>July 18, 1957</u> and that death occurred at <u>3:30 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Bowers</u> M.D.		DATE SIGNED <u>7/17/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 21, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fine Grave Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Hartenstein</u>		24a. REC'D BY REGISTRAR <u>7/20/57</u>	
ADDRESS <u>New Freedom, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Gaulton</u>	

RECEIVED

UL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07263

Reg. Dist. No. 35

07275

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> c. LENGTH OF STAY IN 1b <u>37 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Meredith Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> X! d. STREET ADDRESS <u>Meredith Rd.</u> • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STELLA</u> First <u>AGNES</u> Middle <u>TROUT</u> Last		4. DATE OF DEATH <u>July 3</u> Month <u>1957</u> Day <u>19</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 1899</u> <u>37</u> yrs.
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>
12. BIRTHPLACE (State or foreign country) <u>Stewartstown Pa.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. FATHER'S NAME <u>Joseph Waltemyer</u>		15. MOTHER'S MAIDEN NAME <u>Margaret Shetter</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>100-1-100000</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>440.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>5 min.</u> (c) <u>Interval between onset and death</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/7/57</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>New Freedom, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam Horsten</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>7/6/57</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Puel</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07264

38

07276

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M d. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 65 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice, Dulaney Valley		d. STREET ADDRESS 840 N. Chapelgate Lane	
3. NAME OF DECEASED (Type or print) First Marie Middle J. Twamley Last		4. DATE OF DEATH Month July Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 24 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Stolba		14. MOTHER'S MAIDEN NAME Josephine---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Florence Cummings		Address 840 N. Chapelgate Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 1837 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phelibitis Left Leg (c) Fractured Hip (Right)		INTERVAL BETWEEN ONSET AND DEATH Sudden 24 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Imobiltization For Fractured Hip Caused Phelitis			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Walking down Hall Slipped & fell on hip	
20c. TIME OF INJURY Month, Day, Year 8 6/15/57 How 8 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Towson Baltimore Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave. Edmondson		24a. REC'D BY REGISTRAR AUG 2 1957	
24b. REGISTRAR'S SIGNATURE Mark Gump		DATE SIGNED 7/5/57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 2 1967

RECEIVED

07277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7mths24days	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Herman		4. DATE OF DEATH Month July Day 4 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofier		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Ulbig		14. MOTHER'S MAIDEN NAME Ella Hennon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 219- 01-7610	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac decompensation DUE TO (c) Generalized severe arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH unknown 2 months unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.5		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28 , 19 57 to July 4th , 19 57 , that I last saw the deceased alive on July 4th , 19 57 , and that death occurred at 5:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7.4.57			
ACTUAL SIGNATURE Gertrude J. Fleischmann		PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leo S. Sokol		24a. REC'D BY REGISTRAR DATE JUL 10 57	
24b. REGISTRAR'S SIGNATURE Paula			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07279

CERTIFICATE OF DEATH

Reg. Dist. No.

07266

14

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Lewis			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 73 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL A. VICARI				4. DATE OF DEATH Month Day Year July 5 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/03	
9. AGE (In years last birthday) yrs. 53		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY Fruit Company		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Vincent Vicari			
14. MOTHER'S MAIDEN NAME Mary Max				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII			
16. SOCIAL SECURITY NO. 212-01-9066				17. INFORMANT Address Clin. Rec. Div, Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION (If any) Chronic bronchial asthma. Chronic pulmonary emphysema. Arteriosclerotic cardiovascular disease. Pneumonia 241X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 23 19 57 , to July 5 19 57 , and that death occurred at 4:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 7/6/57							
ACTUAL SIGNATURE Rolando P. Ponce de Leon M.D. 7/6/57							
PHYSICIAN'S NAME (Type) ROLANDO P. PONCE de LEON Fort Howard, Md. 7/6/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Texas, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm Cook-Blight, Inc 6009 Harford Road				24a. REC'D BY REGISTRAR DATE 7/6/57		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

RECEIVED

17 9 1957

RUTHERFORD, N. J.

07278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowson, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Greenspring Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Gilbert Last Wadsworth		4. DATE OF DEATH Month July Day 31 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1879
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Wadsworth		14. MOTHER'S MAIDEN NAME Mary Alice Wadsworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 0 X			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 57 , to July 31 , 19 57 , that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-31-57			
ACTUAL SIGNATURE Bruno Radauskas M.D.		PHYSICIAN'S NAME (Type) Bruno Radauskas Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/6/57		22b. DATE THEREOF 8/6/57	
22c. NAME OF CEMETERY OR CREMATORY Union Mt. Anatomy Board		22d. LOCATION (City, town, or county) (State) Baltimore, 295, Greene St.	
23. FUNERAL DIRECTOR'S SIGNATURE Union of Md. (Anatomy) 295, Greene		24a. REC'D BY REGISTRAR DATE 8/6/57	
24b. REGISTRAR'S SIGNATURE John P. Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1907

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07281

CERTIFICATE OF DEATH

07268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emilio Middle Von de Hyde Last Weber				4. DATE OF DEATH Month July Day 8 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1873	
9. AGE (In years last birthday) yrs. 83?		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Unknown Von de Hyde			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25 , 19 57 , to July 8 , 19 57 , that I last saw the deceased alive on July 8 , 19 57 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslers M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.				DATE SIGNED 7-8-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickens & Sons - Baltimore				24a. REC'D BY REGISTRAR 201 10 57			
24b. REGISTRAR'S SIGNATURE							

BUREAU V. S.

JUL 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07269
07282 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Gwyn Oak</u>	LENGTH OF STAY (in this place) <u>2 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>BALTO</u>	<u>3601.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AUGSBURG Home</u>		STREET ADDRESS (If rural give location) <u>ROSELAWN AVE</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ADOLPH F WENDEL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 23 1957</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWER</u>	8. DATE OF BIRTH: <u>OCT 30, 1867</u>
9. AGE last birthday: <u>90</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>BALTIMORE</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
13. FATHER'S NAME: <u>ADAM WENDEL</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZ.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>6811 CAMPFIELD RD</u> <u>Records AUGSBURG HOME</u>			
15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.0</u> <u>Broncho-Pneumonia</u>		<u>2 wks</u>	
ANTECEDENT CAUSE (S) (B) <u>Arterio-Sclerotic Heart Disease</u>		<u>4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized Arterio-Sclerosis</u>		<u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAM NFR)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14, 1955</u> , to <u>July 23, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>11:20</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Paul L. Chamberlain</u>		DATE SIGNED <u>7/23/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 26, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/24/57</u>		24. FUNERAL DIRECTOR <u>PAUL A. HEEMANN</u> ADDRESS <u>6067 HARE RD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

UL 25 1957

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07283

CERTIFICATE OF DEATH

07270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd</u>		d. STREET ADDRESS <u>2225 North Howard</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Sept 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hereford, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Doris Newmuis</u> Address <u>1420 Herbert St Baltimore 7</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>one 3 yrs -</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5, 1957</u> to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>12 July 1957</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D. <u>Cockey Swills</u>		DATE SIGNED <u>12 July 57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>	22d. LOCATION (City, town, or county) (State) <u>Hereford, Balto. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Lohman</u> ADDRESS <u>1701 Mc Culloch St Balto, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

BUREAU V. E.

FILE NO. 1037

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG218 7-23-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Essex, Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Essex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 Thompson, Blvd.	
3. NAME OF DECEASED (Type or print) Barbara M. Winkelman.		4. DATE OF DEATH Month July Day 14 , 1957 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1865
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) None
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Harry C. Winkelman, Thompson Blvd. Essex.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Anteriosclerotic Cardiovascular Disease DUE TO Carcinoma Left Breast (c) 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs 10 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from July 10, 1957 to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 50 M, from the causes and on the date stated above.	
ACTUAL SIGNATURE M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type) M. Baumgardner		DATE SIGNED 7/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/18/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Eastern Ave.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home		24a. REC'D BY REGISTRAR 16 1957	
24b. REGISTRAR'S SIGNATURE Edith Hurley		24c. DATE 7/14/57	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Handwritten: 51-114-21 July 10-21 July 17 1957
Handwritten: Myocardial infarction
Handwritten: Burial in St. Mary's Cemetery
Handwritten: 10/1/57

RECEIVED
 JUL 16 1957
 BUREAU V. S.

(7285

CERTIFICATE OF DEATH

07272

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Home		d. STREET ADDRESS 5123 Wetheredsville Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle L. Last Wright		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1882
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ely Lilley		14. MOTHER'S MAIDEN NAME Eleanor Hyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Lee Wright		Address 9 Wyndcrest Ave. (28)	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 min years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1957 to July 2, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 7 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wetheredee Fort M.D.		DATE SIGNED 7/3/57	
PHYSICIAN'S NAME (Type) Wetheredee Fort			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-1957	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W. North Ave.	
24a. REC'D BY REGISTRAR JUL 5 '57		24b. REGISTRAR'S SIGNATURE Arthur Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 5 1957

RECEIVED